Title

Some Butterflies Did Come: A Proprioceptive Ethnography of Global Health and Care in Kono District, Sierra Leone

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Some Butterflies Did Come: A Proprioceptive Ethnography of Global Health and Care in Kono District, Sierra Leone

by

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DISSERTATION

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Iŋ gɔi ka!

On the Title

"Long time ago, some butterflies did come," an old Kono man named Fengai told me in May 2021. He recounted a memory from his childhood: one day, out of nowhere, a swarm of white butterflies darkened the sky and descended on Kono. This, Fengai said, portended an imminent crisis or war. The abruptness of their arrival from some unknowable place, the uncertainty about why the butterflies were there, but the sense that something bad would soon unfold reminded me of how people today describe the waves of personnel, interventions, experiments and technologies that descended on the region during the civil war, the Ebola epidemic, and several humanitarian "crises" in between. The butterflies were not there to help, Fengai explained; they just signified that death was coming and that it would be left to the Kono to figure out what to do. The butterflies, he added, "were all white."

"The Kono knew that this war was coming," Fengai said. But some did not wait. Those who "knew what was what" took matters into their own hands; they morphed into leaves, using powerful medicine and magic, "well protected by their *juju*." As leaves, these people floated down the river all the way to Freetown. And there, "they protected Sierra Leone with a big net so that the war would not come." And that war, Fengai said, "never happened, it never came."

Some Butterflies Did Come: A Proprioceptive Ethnography of Global Health and Care in Kono District, Sierra Leone

Raphael Frankfurter

Abstract

Some Butterflies Did Come is an ethnography of people's relationships with life, death and care in Kono District, Sierra Leone, as made visible through their withdrawals from regimes of global health. Kono, with its high mortality rates and deeply impoverished rural healthcare system, has been a ground zero for evolving phases of humanitarian global health. But as regimes of care targeting varying crises, epidemics, and patient populations have come and gone, the quandary—*why are patients not seeking out care, even when it is available?*—has consistently recurred. Drawing on twelve years of engagement with the region, I eschew rational-choice paradigms for addressing these withdrawals, and instead attune to the uncertainties, ambivalences, dispositions and affects that shape people's trajectories through Kono's plural landscapes of health and care.

Each chapter presents an ethnographic immersion in a particular domain of everyday life that colors people's relationships with regimes of global health. From Kono's diamond mines to Paramount Chiefs' compounds, remote public clinics to non-governmental organization (NGO) offices, I trace patients' everyday encounters with postcolonial politics, political economies and landscapes of local healing, and their entanglements with fleeting but often-illusory regimes of humanitarian care. These serial "humanitarian juggernauts" have brought with them spectacular promises and possibilities, yet, at the same time, the threat of arbitrary death has remained for many a proximate and lived-with presence. Across different phases of global health concern and among different groups of patients—war survivors and pregnant women, chronic disease patients and those suffering from Ebola—I follow the subjects of these regimes of care as they seek out

and then withdraw from Kono's healthcare system. I center how encounters with regimes of global health are perceived *proprioceptively*—that is, in terms of my interlocutors' embodied senses of *place* and *positionality* vis-à-vis care as they endeavor to maintain balance in and live through a world wracked with life- making and -breaking contingencies. Throughout, I consider whether these withdrawals from care might constitute a peeling-away from, critique or refusal of the illusory promises of neoliberal global health that at once have great bearing over relations of care in Kono, while consistently leave intact the structural conditions of people's vulnerability to capricious illness and death.

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Introduction

A new NGO had entered the Koidu Government Hospital, with plans to turn it into a Center of Excellence and its flagship West African facility. This NGO was different from the ones that had preceded it: rather than just giving periodic supply donations or workshops for government nurses, it promised to hire healthworkers directly to provide clinical care on the wards, drugs to keep the pharmacies running, new imaging technologies and a power system. Since the end of the country's civil war in 2001, this was the first NGO to embark on anything so substantial in the hospital.

By 2021, the hospital was abuzz with new expatriate African and European clinicians, equipment and diagnostics. Many people in scrubs walked quickly from ward to ward across the graveled grounds. The Minister of Health had traveled to Kono for launching programs at the facility and to hear the stories of patients whose lives had been dramatically saved through the NGO's free surgeries and medicines flown in from abroad. The wards, newly painted, were packed with people now, some coming all the way from Freetown having heard of the new facilities in Koidu. But my friends and interlocutors from Kono were, at times, rather sober about this latest cycle of NGO promises: yes, the x-ray and oxygen plant were important resources for the region, but the extortion within the wards had continued, the care offered by the nurses often seemed of dubious efficacy, and all these new layers of bureaucracy that the NGO had implemented to better track data and coordinate departments and streamline management just seemed to lead to more frustrations. *"Tooooo much bluffing,"*[1] my long-time friend and assistant

[1] Bluffing, in Krio, means strutting like a Big Man, making conspicuous and maybe even inflating one's high-level position

David would say after his once-a-month trip to get his blood pressure checked (which continued to be an all-day affair.) He was irritated by the "Big Men" bureaucrats who yelled at him to sit and wait for hours on end, sometimes long after the clinicians had gone home. He sensed that some of the government nurses now were "bluffing" their expertise with all the new equipment like the x-rays, riding high from all the NGO and political attention, and that the new record-keeping systems and protocols had become alibis for more disregard. "You can't just come in and get your blood pressure taken, *that is not the protocol,*" he imitated the nurses as saying. They would redirect him to go get a signature from another clinician, or tell him to visit the outpatient office or to pay something at the hospital cashier. And, while the wards were much better kept than before, the hospital was still overcrowded. Many people still died there. "*Toooo much bluffing!"*

Every time a local politician or representative of the NGO spoke of the hospital in public or in the media, they foregrounded the new developments with a comparison to the past. "*Before* this hospital was a place of misery, where people went to die, with just two doctors for 600,000 people, no electricity, no water, no oxygen, no x-ray. *Now* it is the best hospital in the country!" The NGO published similar statements and accolades on its websites, letters to donors, and viral fundraising campaigns. Even in more intimate conversations in Kono, when people like David complained about their experiences trying to get care from the outpatient centers, others would jump in: *"it could be worse, one should be grateful for what is there now! They are trying, that NGO is really trying."* One friend who had suffered a horrific pleural tuberculosis infection had recently been transported from the capital city all the way to Koidu for emergency surgery to drain his lung. He was blown away by the care he received: *"Ohhh, those people really tried!"*

So I was surprised when a local radio station, as part of a month long investigation into the corruption among NGO staff based at the hospital, made a sort of satirical poem about the triumphant claims emanating from the hospital, its workers and its US-based fundraising staff. I was forwarded the recording on WhatsApp. In the gravely, nasally voice characteristic of Sierra Leonean comedy programs, the narrator spoke in quick *Krio*[2] inflected with a tone of exaggerated bewilderment:

Professionals!
Yeah professionals!
Professional medical doctors!
Yes!
Our Government Hospital is the first among equals!
Yes, in the country now we are number one!
For guess what?
The professionals that we get there, eh!
They advise that any bed should have 15 children on it!
Yes, that's professional advice!
…
One advice that they give there….
you get…eh….psychiatric headache!
You get… asthmatetitic toothache!

…
Professionals!
….
It's very good advice to pack 10 to 15 children in one bed.
International!
International!
Listen everyone!...
You will hear sickness[es there] that you never even heard of before!
It's so the scientists say…
'The combination of different substances may result to another'
Soooo the substances of the sickness are being combinated
So I don't even know what type of sickness they want to make!...
Professionals!
Please please listen to this advice!
You know we are professionals!

[2] *Krio* is an English-based creole language that is the *lingua franca* of Sierra Leone.

You are expertisms, not expertise-o!
…
We are munku people [fools]!
In fact, they call us "local people."…
Maybe it's munku business, but please, we want one child one bed.
We beg!
Our munku business, that's what we want!

Over the years, I had heard many people speak of the global health NGO economy and who really benefited from it with irony, skepticism, frustration. But I had never encountered such a public, scathing critique of an international NGO's claims to bring transformation to the region's healthcare system— while people there continued to suffer in ways they themselves *knew* were egregious. And this was an NGO that actually supported real clinical care, of which thousands of people were now availing themselves!

I anticipated how some people would respond to the recording—*oh, that radio man is aligned with the opposition party, once they can take responsibility for the hospital, he will be saying a different thing!* Or, *that man just wants a job with the NGO.* Or, *he's just out to get the deputy manager of the NGO, who comes from a competing political cabal.* The humanitarian political-economy, and critiques of it, are always presumed to be enfolded into local political squabbles.

But the poem also voiced a rejection, a definitive refusal, that seemed a sharpened articulation of a relationship many in Kono hold towards the humanitarian landscape of care—a relationship I had been trying to wrap my head around for years. This was a relationship born not of just frustrations with the current state of the Koidu Government Hospital, but which had emerged over decades of living through these waves of global health NGOs coming and going, bringing promises of radical transformation in lives and life-chances that often did not transpire.

Scatter-shot donations of infrastructure, technologies, experiments, and some healthworkers would come as well, along with new ways of describing the region's problems and what Kono people ought to do to resolve them— all while ordinary people continued to face poverty, illness, capricious death. In this context, one comes to encounter all claims of care with a kind of skepticism, a lack of faith—an awareness that, no matter what the politicians and NGOs say, one's ability to secure care when one's life is at stake simply cannot be counted on.

I would get brief insights into this relationship of dissolution through jokes, rumors or subtly ironic asides people would make in coffee shops about the NGOs' intentions: *so so SO many dollars flow through that NGO and its cabals while we here SUFFER!* Or, as David liked to say: *the only ones who truly have their lives changed by NGOs are just those who get hired by them!* I would get a sense of how this relationship worked as I watched people in Kono so emphatically partake in health messaging campaigns, dancing to loud speakers blasting donor-driven jingles about the importance of delivering in the clinic, enjoying the food and drink, all the while knowing that said clinic had few drugs in it and was no place for a laboring mother to go. And I particularly learned of people's mixed feelings about these regimes of global health in Kono as I followed patients through disjointed landscapes of public and humanitarian healthcare. Many times, they would grow frustrated, increasingly hopeless and eventually withdraw from the endeavor entirely onto a different mode of making-do amidst debility.

Was this all a "refusal" of global health, of how Kono had become such a staging ground for this strange new landscape of NGOs, behavior-change interventions and other development projects that left conditions of poverty in-tact? I had not thought about it that way before, and am still wary of that term. This was no absolute, articulated politics of refusal (e.g. Simpson 2014). The poverty, the illness, the hunger is visible everywhere in Kono, and my interlocutors are not

shy about making it clear that they *need* money, healthcare, and food, no matter where it comes from. The NGOs just so often don't attend to those needs.

But, as Zora Neal Hurston (Hurston 2008) writes, refusal too can take the form of keeping "that which the soul lives by" out of sight. This is how her African American interlocutors resisted the white folklorists who traveled down to Florida to gather and understand their stories:

> The theory behind our tactics: "The white man is always trying to know into somebody else's business. All right, I'll set something outside the door of my mind for him to play with and handle. He can read my writing but he sho can't read my mind. I'll put this play toy in his hand, and he will seize it and go away. Then I'll say my say and sing my song (3).

In Kono, the irony, the going-along-with-the-programs with little belief in what they offered, in David's words (further explicated in Chapter 4), the "seeing" humanitarian interventions without really being invested in what they "meant,"— maybe this was, in Hurston's rendering, "a feather-bed resistance. That is, we let the probe enter, but it never comes out" (2). And so the global health technocrats and expatriate NGO workers, confounded, fund more launchings, more workshops, more signboards since, in the end, people still do not seem to be going to clinics as the signboards tell them to do. I too had come to know that certain things would be held out-of-sight by my interlocutors, or embodied but not articulated, as a kind of resistance. After all, I had also landed in Kono twelve years beforehand attached to this strange economy of people, resources and transient regimes of global health and care, even if I thought of myself as observing, critiquing and peeling off from it, more and more.

Over the years, I often asked David what he thought of all these new healthcare institutions operating in the region. Mission clinics popped up every year, ethical diamond

mining initiatives distributed boots and raincoats to those shoveling through sand near his house, announcements were made about free healthcare and school fees that often didn't amount to much, and there were workshops after workshops after discos after t-shirt distributions after dance parties after parades on hygiene and ending malaria and rejecting traditional healers and overcoming the trauma of the war and climate change resilience and One Health and HIV and gender based violence and community animal healthworkers and tuberculosis. All this activity promising such radical transformation in Kono, so much NGO *wahala,* so many people and so much money wrapped up in this industry— and sometimes some real (medical and material) help. And yet, as Kono people like to say: *"At the end of the day, I didn't see no improvement."* Most people described life in Kono as getting worse each year, not better.

"*Hmmmm*,*"* David would grunt with a single chuckle. "We see these things, and the people involved enjoy. But we know. We know. *A de tɛl yu,* we know…" I was never quite sure who he was indicting in these elliptical asides—who "the people" enjoying were (the Kono enthusiastically if half-heartedly partaking in the humanitarian economy? The well-paid young expatriates?) and who "the we" were (the impoverished Kono subjects of all of these "interventions?" The organic intellectuals like himself?)

Perhaps this radio program, as a kind of rupture in the performance of the whole field, finally revealed something of what he conveyed. David was fed up, and yet stuck: he wanted an end to the pressing economic precarity and he wanted healthcare he could depend on to save his life, but he could no longer put his faith in any institution's claims to provide it. "*Maybe it's munku business, but please: we want one child, one bed."*

*

For many years before this poem aired, I had been considering people's conflicted relationships with global health and care in Kono—or rather, those conflicted relationships had constantly confronted me. As an NGO intern and an undergraduate anthropology research assistant, a public health director and a graduate student in anthropology, and while working with different groups of afflicted people – war victims and HIV patients, pregnant women and new mothers, children and surgical patients, Ebola victims and survivors – I was always puzzled by the fact that the question— *why do many people not seek out care, even when it is (somewhat) available?*— recurred alongside each evolving phase of humanitarian global health.

I watched as war-wounded and amputated civilians seemed uninterested in improving their lot through prosthetics and physiotherapy, and HIV patients did not take their free anti-retroviral medications. I learned that mothers delivered at home, instead of at the hospital; children were brought to clinics too late; and, during Sierra Leone's most defining recent health crisis, Ebola patients hid in their homes against public health imperatives. In the halls of the Koidu Government hospital, Sierra Leonean and expatriate clinicians talked relentlessly of the frustrations of their patients' behaviors: they came too late, they absconded at random times, they did not take their medicines, they did not come at all. For several years, I inhabited a role as a practitioner; I hung heads with behavioral health experts to tinker with messages and models to nudge people towards the healthcare system. I also worked with donor agencies to saturate Kono with resources, programs and expertise to increase "uptake" of healthcare services. In some ways, I came to understand that the figure of the Non-Adherent Patient who does not just behave in unusual ways but who must be *implored, convinced, accompanied,* even *wrangled* to go to the clinic in order to save his or her life propels all global health in Sierra Leone. This troubled me,

this double-assumption that accompanied each new phase of intervention: that *this time* healthcare would get better for people, but even so, that it would need to be followed immediately by an effort to convince patients to want it.

Within the field of public health, these frictions were characterized as *low rates of clinic uptake* or even *resistance to care,* stemming from patients' cultural differences, poor health literacy, or a vague allusion to the lack *trust* in public healthcare systems in a place like Sierra Leone (e.g. Katz et al. 2013; Kelly et al. 2017; Dhillon and Kelly 2015; Vinck et al. 2019). Generations of international health efforts mapped out these resistances and cultivated work-arounds to get care delivered to most remote and resistant places (e.g. Foster 1976; Nichter and Kendall 1991). Generations of social scientists suggested a relationship between stigma, depression and fatalism in the face of illness, or innovated new ways of integrating ethnographic knowledge of culture into regimes of public health discourse and care (e.g. Janes and Corbett 2009). Critical medical anthropologists traced the structural barriers that prevented people from accessing care, even when they seemed to be refusing it; and reflected on the forms of emotional detachment towards children and kin that can emerge in conditions in which so many of those children and kin died (Scheper-Hughes 1993). Others elucidated the relationships between dispossession, anomie and agentive acts of bodily-harm (Garcia 2010; Stevenson 2014). In a sense, the issue of why patients navigate systems of care the ways they do—and in the process confound regimes of biomedicine and public health— has been the original, and central, question for the field of medical anthropology.

Critical race theorists portrayed a population's engagements with and refusals of healthcare as political. Aligned with the anticolonial resistance movement in Algeria, Franz Fanon wrote that refusal of medical care was not just an inevitable consequence of failed or

inadequate resources. Rather, “acts of refusal or rejection of medical treatment are not a refusal of life, but a greater passivity before that close and contagious death,” central to the condition of the colonized. In this formulation, refusing medicine and its relationship to colonial forms of domination may be, in Derieck Scott’s words, a “muscular and political posture” (Scott 2010:73), or at least a kind of signifier of the ubiquity of social, as well as biological, death in the colony. Achille Mbembe (2001) took this stance even further: refusal of life is not merely an issue of subaltern resistance; in the African postcolony today, death is actively meted to affirm and strengthen forms of political authority. Perhaps those who seem to be agentively refusing care were merely fulfilling their fate in this “economy of death” (Mbembe 2001:14).

I immersed myself in this literature as I tried to make sense of what I was seeing on the ground: an HIV patient quietly withering away on her bed, next to a half-empty bottle of anti-retrovirals; an Ebola patient who hid for days in his house, being cared for by his family, despite knowing and articulating the risk of infection; the haunting image of a young mother who left the clinic in which I was observing without taking the life-saving nutritional paste to feed her critically-malnourished child.

But while refusal of care in Kono certainly was a widely dispersed issue, often, when I came to know individual patients and their stories, the moments of refusal were less clear cut than those which Fanon, Scheper-Hughes and other scholars had written about. There was an elderly man I met, for instance, who had saved up for months for a hernia surgery. The surgical wound had ruptured into a disabling and deadly fistula, but after all the effort at securing the surgery, he remained at home as the wound slowly spread across his groin, despite knowing that free surgical care had been advertised by an NGO in the District’s capital. I came to think of these moments as *withdrawals* from care more than outright rejections. For these *withdrawals*

also occasioned *reentries*: sometimes patients who had adamantly left care one day would come back to the clinic or abruptly start taking their medication the next. The elderly man with the surgical wound readily entered an NGO ambulance when one arrived at his home, and he was brought to the hospital where his wound was promptly repaired the next day.

Furthermore, the context in which these withdrawals were unfolding did not neatly align with the analytic schemas offered by decades of medical anthropological scholarship. Life—and illness—in Kono is not met with clear forms of bureaucratic and state indifference, nor outright colonial violence. Rather, serial humanitarian global health interventions had coalesced on the region claiming to attend to people's health, and relentlessly imploring people to seek and adhere to care and thus, in a sense, to life itself. Every road, every village, every clinic in Kono is covered in billboards marking NGO programs and health messages, and NGOs maintain huge offices and fleets of vehicles in the region. Transient social, economic and medical support programs have touched, in one way or another, most people in Kono. In other words, the State and NGOs' "gaze" was very present in Kono—a veritable biopolitical economy of sorts— even if the actual material conditions of people's lives did not always substantially change as a result.

Throughout, I engaged my Sierra Leonean colleagues and interlocutors who worked in hospitals, NGOs and clinics about these confounding moments of withdrawal and the fact that they kept recurring over the arcs of our careers in global health. Often, those colleagues would respond with a flippant reiteration of the behavioral public health explanations they had heard in workshops and NGO trainings—*stigma*, *culture, poverty, ignorance*—but I frequently had the sense that these scripts were standing-in for more troubling realities about the fallibilities of our work, keeping those painful reflections at arm's length. At other times, these moments of withdrawal seemed just as aporetic to my interlocutors, colleagues and friends from Kono. These

moments, when they seemed to have reached the limits of their own ethnographic comprehensibility of this place, were particularly profound. One nurse I knew, not one to express much vulnerability or introspection, told me after a long day in which several children had died after their parents had come to the clinic but then returned home before the children could be treated: "There's one thing I just don't understand about this place. You see these children die of stupid things—lack of food, lack of care, lack of patience at the clinic. You see people with wounds and sicknesses left here, everybody says they don't have the money to get them to the city where their lives would be saved. No money, no money to help. But when they die…you know, without any doubt, there *must* be a cow at the funeral." In other words, the nurse explained, these withdrawals were not *just* a result of lack of access, resources, or dysfunctions in the healthcare systems—though all of these factors certainly played a part.

Dissertation Focus and Orientation

Some Butterflies Did Come is a proprioceptive ethnography of people's relationships to life, death and care in Kono District, Sierra Leone, as made visible through their withdrawals from global health care. Throughout, I pursue these questions: What does it mean for people in Kono not to *trust* a system of care? How does that disposition of skepticism towards care, that *feeling,* come to be? What are the historical antecedents to these relationships to life, death and care? How have the recent politics of global health shaped this relationship in a landscape of care now overdetermined by the transient models of humanitarian regimes of intervention?

As I struggled to think through my notes and the stories of people's conflicted encounters with serial regimes of global health, I found myself returning to the image evoked in the old man

Fengai's story of the butterflies that descended on Kono portending war (recounted in the epigram.) After listening to Fengai that day, David had turned to me and, with shrug, said: "I think he must have meant locusts, not butterflies." Maybe so. But the story also conveyed something about a type of *space* Fengai occupied in Kono, in which life, death and relations of care unfold in ongoing ways even though, any morning, a new wave of unknown people, objects, actors, events—insects, NGOs or crisis-caravans (Polman 2011)—might darken the skies and inundate the fields. Fengai's story (or at least the way he told it) seemed to conjure a positionality of witnessing the butterflies with a certain affective distance, born of the histories—perhaps familiarity—of these opaque, unprecedented, bizarre but spectacular incursions materializing in Kono from afar. Amidst the vertigo of the butterflies appearing with little warning it was left to Fengai and the people who "knew what was what" to ascertain the threats to Kono lives and worlds, and to mitigate those contingencies on their own. Many of my interlocutors who faced prolonged or uncertain illness in Kono, I realized, described a similar effort to maintain a sense of *balance* for themselves as they ascertained the possibilities for health and care underneath opaque, often-fleeting regimes of humanitarian intervention, and ongoing conditions of precarity and illness.

I use the term "proprioceptive ethnography" here inspired by Lauren Berlant, who writes that her book *Cruel Optimism*, a central text in contemporary affect theory, represents a "kind of proprioceptive history" (Berlant 2011:20). I also use this term in relation to Fengai's position of watching and discerning the butterflies that came. Proprioception is the body's ability to sense itself amidst movement and action. Proprioceptive neurons in muscles and tendons throughout the body register joint positions, levels of stretch and degrees of tension. All of this information is synthesized in the brain as a gut and reflexive knowledge of the body's position in space. One

can stand up straight with one's eyes closed, or put one foot in front of the other without looking down, due to this proprioception. Movements are finally adjusted and constrained between opposing muscles (one's elbow does not snap by just forcefully straightening one's arm).

Proprioception, in other words, is the body's attunement (both conscious and unconscious) to dynamisms and contingencies, as it seeks to maintain equilibrium at many different scales: in individual muscles, in joints and in the body as an aggregate entity of feelings. This term evoked for me an image of my interlocutors in Kono constantly accumulating experiences vis-à-vis the health and care from many different domains of social life, synthesizing these experiences with lived histories and relations to the body and illness, all inflected with (constrained and modulated) agency and the singularity of subjectivities. This sensorium in turn coalesces into peoples' movement towards and away from various sites of care as they endeavor to maintain some equilibrium and balance amidst contingencies. A proprioceptive ethnography of global health, then, centers what regimes of global health do to people's *senses of place* in the world—and how, in turn, this positionality shapes relations to care.

I must preface here by stating outright that I do not yet have a clear language for the relationship to care in Kono that I write about. I often feel more like I am tracing the contours of an affective knot that resists naming, the collective experiences and scenes that have engendered it, than describing a consistent disposition or orientation towards the health, life and care. As a result, my ethnography dwells more in these experiences and scenes than in people's articulation of their own affects, feelings and dispositions. This affective knot emerges through culture and diverse epistemologies of healing just as it does from people's lived experiences of exclusion from the healthcare system. It comes from long and embodied histories of colonial and neocolonial predation, just as it does from cynicism about the contemporary politics of NGOs

and the graft they enable. It comes from the stunningly high mortality rates in Kono and the proximity of arbitrary death that people there live with. But it also comes from living in a place in which one's notion of how lifesaving healthcare materializes is tethered to transient regimes of donor compassion emanating from thousands of miles away, and in which the sources of one's illness and vulnerability are consistently obfuscated by technocratic and expert renderings of Sierra Leone's present conditions.

The 2014-2016 Ebola epidemic was a seminal moment in the history of the region's healthcare system, when the underfunded, understaffed and underequipped healthcare system became the site of thousands of agonizing deaths and even more Ebola transmission. Like a swarm of butterflies landing in Kono, a humanitarian juggernaut at a scale never seen before in this impoverished country materialized rapidly, alongside all sorts of technologies, foreign personnel, fleeting infrastructures of care, promises about how things would change in the aftermath, and a lot of death. Much of that juggernaut is now gone, the promises reneged or, in the words of one of my interlocutors (in Chapter 4) "forgotten." The specific horrors of this period emerge in conversations and memories throughout my ethnography, but my longitudinal relationships with interlocutors—before, during and after the epidemic—also force me to attend to ways that this epidemic did *not* necessarily overdetermine people's relationships to the healthcare system, and perhaps ought not to be put front-and-center in this story. These regimes and histories of global health—of which Ebola is but one part—make or break life chances with a kind of indifferent unpredictability, but more often than not promise more than they deliver, for they consistently circumvent the material sources of suffering and illness. And still, in Kono, people's living, caring, theorizing—and dying—goes on.

The term *refusal* to describe this collective relation to care in Kono, for the reasons described above, is too clear cut. Most of those I speak with are adamant: they want healthcare, want to be cared-for, and want to have their health restored—and yet put little investment in any one institution's claims to have their health or their interests at heart. *Rejection* is far too deterministic. *Skeptical* as a state of unsettling perception, or, in Stanley Cavell's words, "the human disappointment with human knowledge" (Cavell 1999:44) perhaps more closely approaches this relationship. *Critique*—as Foucault puts it, the "art of not being governed quite so much" (Foucault 1996)—also seems apt, but perhaps too conscientious and cognitive rather than plastic and embodied. Elsewhere I have used the word *discerning* (Frankfurter 2021), but there is more pathos, more a sense of cumulative letting-down, than that word evokes. This relationship to care is born of a sense that institutions and people are "*bluffing*," to borrow from *Krio*—over-stating their capacities, flaunting their status, and cannot be trusted. It is not a hopelessness, nor just a frustration; perhaps a *reticence* or *resignation* but one that leaves space both for anger but also giving things another-go. As I explore throughout, this relationship to care often leads people to turn *inward* and to *hold their living and dying close*. My overall argument, elusive names aside, is that this relationship to care in Kono is structured by a shared history of encountering regimes of humanitarian care that bring with them serial waves of spectacular promises and possibilities, while, at the same time, death remains an arbitrary, ubiquitous, proximate and lived-with presence.

The structural and material forces of exclusion, the human costs of the political-economic histories and arrangements that have so impoverished Kono District, are everywhere in this ethnography. I try to name precise ideological, epistemic and institutional sources of the region's impoverishment when I feel I can; often times, my immersions in the often-banal world of global

health and humanitarian institutions leave unclear where the bogeyman knowledge-power or extractive geo-political apparatus actually lies (more on this in the Interlude). Regardless, in Kono, real, complex people with their own interiorities, critiques, desires and relations to politics make their lives amidst these structures of exclusion and vulnerability. The type of longitudinal ethnographic relationships I have had in Kono, the ways I have learned from interlocutors (each with their own idiosyncracies) of how they exist and build lives, relationships, futures and philosophies amidst the structural violence, make me wary of *a priori* tethering behavior, action, affect—and indeed relations to institutions of care—back to the structural alone. I do believe that my interlocutors' own ways of encountering the geopolitical forces to which their lives are subject, or, in historian Nacy Rose Hunt's words, their "sizing up navigating, manipulating the milieu…[their] gift and capacity for activity, for motion [that]…begins with skills in acute observation—without denial" (Hunt 2016:253) should be placed alongside social theory of structural violence. Sometimes, in fact, my interlocutors in Kono complicate efforts to rectify global health inequities; more often, they offer their own embodied critiques of structural violence and illusory regimes of care, even if in the form of "bantering, jesting, deriding, daydreaming too" (Hunt 2016:253), and in the process, do real work to trouble durable and oppressive relations of power. In attuning to their stories, to the domains of social, psychological, affective life into which the material is encountered, theorized, enfolded—in "peopling" and humanizing critical theories of structural violence and health (Biehl and Locke 2017:11)—perhaps similarly unanticipated knowledge of and movements towards the political and political-economic might emerge.

Entanglements

My engagement with Sierra Leone began in 2010, while I was still an undergraduate student and at the height of the burgeoning campus "global health" movement. Vaguely interested in medicine, culture, the intersection of the two—and exposed to something of a "moral voice," like so many others, through the writings of Paul Farmer—in the summer of 2010 I was given the opportunity to dip my feet into "global health work" firsthand through an internship with Ichende International.[3] Ichende—the Kono word for "health"— I learned, had been founded to serve civilians amputated during the country's civil war by operating a primary care clinic and outreach programs in the far east of the country.

Several weeks later, I stepped into thick tropical air and saw the lit-up profile of "W_llcom_ to Free _own." After a nauseating journey on a rented out minibus taxi from Freetown to Kono on cushion-less seats, I set down to work with my mentor, Peter Locke, an anthropology post-doctoral researcher, on a project to assess chronic pain and post-traumatic stress disorder (PTSD) rates among the amputees. A Norwegian NGO, I learned, had resettled these war-wounded civilians into concrete villages that they called "Amputee Camps" ten years earlier. For a few years, bags of rice had been dropped off monthly by a major international NGO, and hordes of journalists and researchers traveled through the region to collect the stories of the war-wounded. Many in Kono came to know the amputees as the recipients of generous aid and free housing. But since then, miles from their original communities, families, and support networks, the amputees had largely been left to make do on their own.

[3] This initial trip, and much of my time in Kono spent as an undergraduate, was organized and funded through Professor João Biehl's interdisciplinary "Grand Challenges" research group on The Social Determinants of Health and the Future of HIV/AIDS treatment.

I remember well the first interview circle with the amputees, when we asked adapted from a standardized trauma questionnaire: “Do you think about the war a lot?” “Do you have trouble sleeping?” “Do you ever forget the war is over?” The answers were all yes, though not emphatically so, and one woman shrugged her hands up and swept them around, beckoning us to look at the surroundings: the crumbling toilet; children with bloated stomachs; small subsistence gardens; Sahr Bintu, a man with part of his neck chopped out, both limbs amputated who was unable to answer all of our questions because, as he said, “my mind is like pebbles.” The woman stared at us firmly: “Our problems are on your desk now.”

The rest of that first trip to Sierra Leone continued in the same vein. I learned to recognize that anxious, fidgety, terrible nervous look born of hunger pains with absolutely no certainty as to when they will be assuaged. I learned more of the destabilizing vertigo the amputees experienced as they got so much international attention after the war but then were left, at the end of it all, with concrete houses in Kono with little sense of what came next. Post-traumatic stress came to seem an utterly inadequate model to describe the lives, memories and futurities of these people: most of the amputees were hungry, nearly all unemployed and many lonely, malaria and other forms of poor health were ubiquitous. But they also did not use the (albeit crude) prostheses that had been donated over the years, and very few (even among those without catastrophically physically disabling injuries) had sought out more stable employment. Sahr Bintu had said, “From the moment I wake up, to the moment I go to sleep, I sit on this veranda and look out at that mountain, where my village before the war was. If the war didn’t happen, I would be chief there.” The war’s continued presence wasn’t constrained to people’s minds, but remained affectively and physically embodied, both creating and continuously coloring their struggles for survival as “disabled” and “unable.”

The physicians in charge of Ichende's clinic sought to turn the findings into a medical intervention that, as doctors, they could actually address, and I found myself increasingly skeptical that drugs—antidepressants, pain relievers or even counseling—would come to ameliorate much of anything of "the violence of everyday life" that the amputees faced (see Scheper-Hughes 1993). Within several weeks of my entrée into global health fieldwork, I was implicated in friction between the objectives and motives of humanitarian medical and psychiatric interventions and on-the-ground-realities that seemed to me clearly to warrant more material support, or at least a more expansive ethnographic lens to wrap one's head around it all.

*

Ichende had been founded in 2006, when an American medical student named Tom, sponsored by a year-long global health fellowship from his medical school, met a recently-qualified Sierra Leonean physician named Osman. The two, Osman once explained to me, saw "the same vision in each other." Tom says that he was very aware that everywhere he went in Sierra Leone people asked for three things: "Food, school fees and medicine." But knew he would have to "prioritize" in this post-war country of overwhelming need, and his training was in medicine. Together, Tom and Osman formed Ichende International, a local NGO that, after several years of implementing health contracts for UNICEF and other large organizations, settled in Kono. Tom and Osman saw that the postwar humanitarian focus on the amputees' wellbeing was quickly subsiding as NGOs shifted their focus to new target patient-populations. Kono, in the far east of the country and on the border with Guinea, had the highest concentration of amputees given that it had been an epicenter of the civil war. This was also one of the poorest regions in the country: decimated by the war, many buildings in the capital city Koidu were still

in ruins, and very little public infrastructure had survived. The District's Amputee Association lobbied the region's Paramount Chiefs for land to build a clinic; across the shiny white building that Tom's parents funded as a medical school graduation present in 2008, the chairman for the Amputees Association painted "Amputees' Clinic." Osman recruited his favorite nurses from the mission clinic that he was working with at the time and promised them comparable salaries, and hired his first Kono staff from the camps.

The clinic opened its doors to HIV patients and then the general population in 2009. Some of the amputees who had been involved in acquiring the land for the clinic predicted that yet again an NGO's short attention-span would leave the amputees to make do with injuries that would endure for the rest of their lives. But patients of all sorts continued to come. That first year after opening, 10,000 patients sought care; by 2011, over 20,000 patients were provided medical services out of the same small building. Amputees, HIV patients, orphans and another 38 of what the NGO called "vulnerable groups" were given free care, but at the time a significant proportion of the clinic's funding came from user fees charged for the general ("non-" or at least "less-" vulnerable) population. The remaining funds came largely from Tom's friends and family in America, especially from his father, an executive at pharmaceutical company. His mother, an energetic woman who threw herself into the nonprofit, took up the task of garnering support and contacts, though she and Tom increasingly fought about the organization and the credit she deserved for her work. And, several years later, she and her husband filed for a divorce, which everyone feared could mean a major decrease in funding if Tom's father became distanced from the organization.

Each summer after that first trip, I returned to Sierra Leone, snowballing ethnographic inquiries beyond the amputees to the HIV patients, pregnant women and children, diamond

mining, the centrality of witchcraft in negotiating the beneficiaries of development projects and local healing. Something in Kono drew me back again and again, and it was certainly not just the suffering or precarity of the NGO: something I found so profoundly fascinating about my relationships with interlocutors, friends and colleagues unfolding in unanticipated ways over many years; my growing familiarity with Kono, fascination with the country's histories and cultural landscape, and attunement to cyclical temporalities of politics and regimes of humanitarian intervention, which at once made day-to-day life more legible but also opened up, each trip, whole new domains of curiosity and ethnographic exploration; the intellectual energy I felt in releasing myself to enough flexibility that gaps in worlds became recognizable, but also junctures viscerally felt. I continued working for the organization in the meantime, and, in 2013, I became "Executive Director," of the US arm of the organization, to work full time to raise more funds and position the Sierra Leonean side to receive larger grants and rapidly grow. The absurdity of this situation, in which I as a young college graduate was so inextricably tied now to nearly 20,000 real people's healthcare in Kono, was a constant preoccupation for me. But this was how the political economy of humanitarian aid in Sierra Leone —on which real people's lives depended—worked. And immersed in the world of global health funding and implementation, I was also aware of how my ethnographic entrée into Kono (as a researcher over four years), and my now substantial relationships with the people and organization there, may have honed both my managerial and strategic sensitivities, in some ways, even beyond more senior colleagues. In any case, my goal in "directing" the organization was to develop a US arm purely focused on fundraising and garnering resources, and to ensure the programs were autonomously managed by Sierra Leoneans on the ground. With a small staff, we launched an office in Boston and sought meetings with foundations, individual donors and health institutions.

We cobbled together donors and grants and soon were operating a clinic, 24-hour maternity center and programs in the Kono Government Hospital.

Early 2015 was the inflection point for the organization, and, in some ways, for Kono's healthcare system. The Ebola outbreak, once uncontained and threatening the world, brought spigots of money at a scale none of us had ever seen before. In August 2015, Ichende formally linked with a much larger organization Alliance for Health Justice, whose directors had sought a partner to launch their own involvement with the Ebola crisis. Kono was flooded with expatriate physicians and nurses and millions of dollars of new health resources. Alliance for Health Justice promised to transform the government hospital into a center of excellence and to remain to financially support the facility until it got there. The organization launched Ebola Treatment Units, hired thousands of community healthworkers in regions Ichende had never worked in before, staffed clinics and hospitals across the country—for doing anything less would be, I was told many times, "fetishizing the small." I ended up managing the effort to develop community health worker systems to identify Ebola patients and accompany them to treatment centers, and was once again tasked with "figuring out" why mortally-ill people were not seeking care.

Over time, through and in the wake of the Ebola epidemic, things changed in the organization and in Kono's landscape of global health. The rapid bureaucratization and the sense that local knowledge was being lost in the pursuit of "professionalizing" the organization led to great tensions, and, at times, a tenor of regret conveyed by some patients and some staff. I was quite critical about all these changes—in many ways out of my own sense of nostalgia, I will admit—and the new directors seemed relieved when I returned to graduate school to pursue dual degrees in medicine and anthropology.

As I returned to being a student and researcher amidst this rapid bureaucratization, I lost access to many of the clinical spaces where I had worked as a researcher and public health director and where I had visited interlocutors and friends in various states of illness and care. This was ostensibly because of the new regulatory processes that the organization had instituted to monitor researchers (a welcome development), but at times felt more like an effort to keep the work, and patients' stories, out of ethnographic scrutiny. This was a painful process of untethering, of navigating the boredom and unpredictability of ethnographic research, but at the same time embracing a new license for intellectual creativity on the peripheries of the team, friends, colleagues and organization that I had worked with for so long.

This critical distance enabled me to rethink my methods of engagement, to free my itineraries of research, to see things beyond the clinic and to get a deeper sense of confusion about it all. I revisited and re-wrote ethnographic and analytic materials from my earlier forays in dialogue with new theoretical texts, ethnographic materials and engagements with interlocutors.[4] I developed a closer relationship with David, my assistant and long-time friend. I had met David years beforehand, when he had seen a group of Americans undergraduates jogging through the town and introduced himself as having a flower nursery on the outskirts of town. He became a constant presence at the Ichende lodge and source of counsel and wisdom throughout my NGO years. After I left the organization, I spent many months living on his farm on the outskirts of Koidu, a plot of land that had been bought by his brother living in Delaware as an attempt to rebuild a family that had been decimated by postcolonial political violence, war and poverty. David's own story spoke to the kind of temporality and capricious futurities that characterize so many life trajectories in Kono: he had grown up a successful academician in a vibrant rural Kono

[4] Chapters 2 and 3 involve direct re-engagements with some ethnography first presented in my Princeton thesis.

household with a great deal of cultural pride, but after the death of his father, an opposition candidate thrust into exile during President Siaka Stevens' reign, David became an alcoholic. He dropped out of school and lived for years a life filled with precarity and violence and surges of fleeting possibility in the war and post-war shadow economies of diamonds, drugs and smuggling. In the process, he had intersected with many strange characters who had each changed his life in some ways: a British man who claimed to have been a special-forces operative, in Sierra Leone to mine diamonds and then harvest timber; an American Peace Corps member who seemed to have gone rogue in the forests of Liberia, and who preached a manic form of Pentecostalism while taking multiple Liberian wives and trying to impart new agricultural techniques to the rural indigenes; another British man who claimed to have extravagant celebrity connections who was also there for diamonds, but only of the "ethical" variety. These stories made me acutely and uncomfortably aware of how I fit into a much broader history of this supposedly "remote" corner of West Africa (called "The White Man's Grave" in a 19th century travelogue (Banbury 1889)) but which really has served as a kind of serial staging ground for Euro-American economic, ideological and intellectual endeavors of all sorts.

Now sober for many years and with little material security but a great deal of wisdom, David lived a kind of quiet life reading Buddhist philosophy, nursing flowers, dabbling in neo-Rastafarian politics and perennially puffing on his *djamba* joints in the lush veranda of his house. David opened my eyes to new cultural and historical domains in Kono missed by a narrowly-applied medical anthropology lens: sodality rites and the myths surrounding esoteric societies; the nuances of the Kono language; people's ambivalences towards customary rule; the violent, ethno-nationalist tendencies that lurk underneath Kono's postcolonial political discourse and

ongoing neglect, tendencies that wracked David with guilt which he could not entirely shake; the melancholia engendered by the sense of cultural and agrarian dissolution in the wake of the country's economic collapse and war. Most important, David was particularly adept at articulating and effecting a sense of living with such precarious, uncertain futures in Kono, without necessarily hope—but with joy and vibrancy and movement nonetheless.

Seeking Care as Vital Force

There is a long history of social science engagement that treats subjects' *will to live* and *seek out care* as empirical windows into broader political, social, cultural and historical conditions. The fundamentally aporetic act of suicide (in relation to a normative, future-oriented telos of the subject that is central to many Western philosophical traditions) has been a grounding object for much of this work, famously inaugurated by Durkheim (1965) in his book *Suicide*. Durkheim studied suicide as a sociological rather than psychological phenomenon: he posited that there is a suicidogenic current running through all populations and social communities, that is strengthened or alternately moderated by particular cultural forms, shared values and dispositions. When cultures' shared traits evolve to become too altruistic or egocentric, or when a population experiences social disruption, rapid economic change or political upheaval, this suicidogenic current may be amplified, leading, Durkheim sought to show empirically, to spikes in suicide rates. While his study and his methodological insistence on the shared and delineated entity "The Social" might now be considered too essentializing, Durkheim's work was innovative in its challenging the reductionism of psychoanalytic approaches to suicide and instead situating psychological tumult in broader socio-cultural contexts.

Threads of this Durkheimian insight can be read in histories of early 20th colonial Africa. European officials and researchers in Africa were concerned with the "depopulation" of African races as evidenced by plummeting fertility rates amidst ongoing imperial expansion and violence. Public health officials, ethnologists and colonial administrators researched the nature of this supposed "Race Suicide" as something of a biocultural phenomenon. Explanations for Race Suicide were made up of largely of what Nancy Rose Hunt calls "tropes of imperial fantasy and overrule" (13): theories of widespread venereal disease stemming from natives' undeveloped morals and excessive vise, and more abstract notions of a collective vital force that was exhausted by changing worlds under the influence of colonialism. These tropes at once confirmed the supremacy of colonial power to administrators, and also reified the technical capacities of new forms of ethnological and public health science to experiment and tinker with the "problem" of dwindling populations. What they did not always do was trace these phenomena to the extraordinary acts of violence that were brought alongside imperial regimes of governance, nor to the role of colonial medicine itself in dwindling fertility rates. Some historians have now hypothesized that the invasive gynecological technologies that proliferated as part of colonial public health programs may have actually contributed to the spread of venereal diseases and resulting infertility (Hunt 2016:164).

In 1940, the anthropologist and physician W.H.R. Rivers wrote of colonial missionaries' own responsibilities for this mass *dying out* in Melanesia. The phenomenon of "race suicide," for him, served as a call to critique the excesses of colonial and missionary conquest:

> The point I wish to emphasise is that through [the missionaries'] unintelligent and undiscriminating action towards native institutions the people were deprived of nearly *all that gave interest to their lives*…. When you inquire of those who have lived long in Melanesia concerning the illness and mortality of the natives, you are struck by the

> frequency of reference to the ease with which the native dies. Over and over again one is told of a native who seemed hale and well until, after a day or two of some apparently trivial illness, he gives up the ghost without any of the signs which among ourselves give ample warning of the impending fate. A native who is ill loses heart at once. He has *no desire to live*, and perhaps announces that he is going to die when the onlooker can see no ground for his belief (Rivers 1920:109; my emphasis).

The (collective) native's will to live, in other words, is sustained by those things that give the native *interest* in life. Under colonization, women stop being able to reproduce, couples stop fornicating, sickly patients become indifferent to or even welcoming of death. And this indifference, this condition, is manifested by the sick native who does not even try to seek out lifesaving care.

The relationship of contingency, politics, social upheaval to the will to live has continued as a focus in critical medical anthropology. Take Nancy Scheper-Hughes' (Scheper-Hughes 1993) *Death Without Weeping*: a stunning ethnography of Northeastern Brazil, this text explores the troubling realities of "maternal detachment" amidst food insecurity and the desperate poverty within the shantytowns on the peripheries of Brazil's sugarcane plantations. Scheper-Hughes writes of mothers quietly abandoning their children, ushering along sickly children's deaths, and not exhibiting what Euro-American readers might expect to be the fundamental bonds of maternal love. The mothers did not name children at birth, did not seem to coddle their children, nor to do everything they could to prevent their deaths until the children emerged from an early childhood period of exceedingly high mortality. Scheper-Hughes argues that these behaviors were not a consequence of lack of health education or promotion necessarily, but in part rooted in a broader and collective "rudimentary pragmatics of saving the salvageable" (Scheper-Hughes 1993:405) In other words, the most sickly children were quietly "triaged" out of the family as acts of care to protect the resources for the other kin. Scheper-Hughes' describes the mothers'

own affective attachments (or lack thereof) towards their dying children as mirroring the bureaucratic disregard through which the problem of child mortality in the shantytowns was effaced by the Brazilian government. In this formulation, emotional life in the shantytowns emerges out of a "political-economy of emotions," tethering the (im)possibilities of certain forms of vital love and care to the material conditions in which these women lived: chronic disease, poor health, constant hunger. This relationship between the material and the affective is a key concern throughout my dissertation, though it is perhaps more fragile and less unidirectional in Kono than Scheper-Hughes' suggests.

Contemporary anthropological work has challenged the notion of *care* or *regimes of public health* as always beneficent and as always optimizing and aligned with patients' will to live. Departing from Scheper-Hughes' original concern with the material requisites for the attachment to life itself, and instead focusing on the logics enfolded into neoliberal biopolitics, state-run health programs and clinical care alike, more recent work reveals how the experience of being *cared-for* in particular ways can paradoxically be felt as violent or untenable. "Dispossession" (Garcia 2010), "anonymity" (Stevenson 2014) and heteronormative logics (Dean 2009) have underlay public health regimes over the last century, and these ethnographies bring into view the troubling ways that impoverished, colonized or otherwise marginalized populations may *confound* or explicitly *resist* these politics of care by harming, or withdrawing from, their own bodies and lives (see also Whitmarsh 2019).

These rich debates on the inadequacies of contemporary regimes of care and their relationships to practices of refusal, self-harm and suicide, have not yet looked at regions of the world subject to the neoliberal regime of public health *par excellence*: that is, postcolonial, post-structural adjustment Africa dominated by humanitarian global health. Much has been written

about the consequences of the anarchic agglomeration of global health actors and institutions across the Global South, from many disciplines—for patients, for health systems and politics, for the ethics of humanitarian practice and knowledge-production, for political economies of care and disregard, and for the mitigation of public health crises like malaria, tuberculosis, HIV and Ebola (Farmer et al. 2013; João Biehl and Adryna Petryna 2013; Adams, Burke, and Whitmarsh 2014; Adams 2016a). This is a very different setting than the neglected shantytowns of urban Brazil or the barren tundra of colonized Inuit territory (albeit with socialized Canadian healthcare available). Sierra Leone is completely saturated in humanitarian programs that implore people to maintain a *will to care*, while day-to-day life remains precarious and brutally impoverished for most people, and the actual possibilities of securing life-saving care from clinics is never guaranteed. Thus, at some level, this dissertation is an effort to explore whether peoples' relationships with a global health apparatus that often appears and is expected by people on the ground to be vacuous and entangled with dubious commitments may be constituted by a kind of politics of resistance; whether patients' withdrawals might even be thought as the "psychic life" of the "thinness" of global health care (Stevenson 2012; Franklin and Munyikwa 2021).

However, the existing literature on the violences of and resistances to care does not entirely capture the ways people in Kono engage with, withdraw from or otherwise confound regimes of global health. First, the swerves and *withdrawals* from the healthcare system of which I write are not suicide, though many patients—like that man who had a necrosed surgical wound, who did not seek out care from the hospital nearby—exist in an intimacy with death. There is a murkiness to this field-site and people's trajectories through it; the mixed and at times-contradictory relations to regimes of care in Kono—seeking care out, and then withdrawing from it; raising the funds for a hernia surgery, and then remaining on the floor when, due to

complications, that surgery became moot—may beckon a different kind of ethnographic theory and approach. Throughout this dissertation, I explore how these impulses and pulls towards and away from care in Kono, at once unpatterned but also in some ways predictable, may also be reflective of a broader condition in postcolonial Africa in which, as Achille Mbembe writes, "the course of life is assimilated to a game of chance, a lottery, in which the existential temporal horizon is colonized by the immediate present" (Mbembe 2002:271). To make broad claims about a collective resistance to care or embracing of death in Kono would efface this central, shared sense of there being always capricious and world-changing contingencies around the corner, and that relations to care and to kin reflect this.

Medical Pluralisms, Multiple Rationalities

In Kono, the fragmented public healthcare system is not the only source of healing available for those facing illness and death. Likewise, patients who withdraw from clinics do not always withdraw from care entirely. As Historian Steven Feierman (1985) writes: "in most African communities several kinds of healers work side by side: physicians or medical assistants, specialists in sorcery or spirit possession, Christian or Muslim religious healers, and others. Multiple authorities co-exist, and therefore no one healer decides the cause or cure of illness in a way which others accept as beyond challenge" (73). Many sections of this dissertation follow the rich literature of medical anthropology that has sought to answer the question: *how and why do people in Africa navigate multiple systems of healin*g?

The study of what came to be called *medical pluralism* (Leslie 1980)—of how and why patients choose certain types of care over others, and how those forms of care operate in tandem

with each other—has taken a number of forms. While some early anthropological theorists offered sweeping theoretical conclusions—Claude Lévi-Strauss, for instance, homed in on the question of *effectiveness,* positing that the symbolic work performed by healers can indeed alter the pathophysiology of disease—most early and mid-20th century ethnographers carried out this work via micro-analyses of particular healing systems and the ways people navigated them. In an influential article on the comparative study of medical systems, anthropologist John Janzen argued against the notion that healing systems are static and instead suggested that political change must be accounted for in studies of medical pluralism (1978a). Jean Comaroff extended this argument in an article on healing among the Tswana of Southern Africa: "[Medical anthropology] can no longer legitimately be viewed as the 'opening' of 'closed' systems: rather, it requires understanding how the dynamic processes of particular small-scale societies engage with encompassing politico-economic forces. Healing is crucially bound up with this (Comaroff 1981:367)." I hold these insights close as I explore how diverse healers and healing practices in Sierra Leone have become entangled with postcolonial Sierra Leonean politics and the expert logics of contemporary global health, and the contested ways that caregivers of all sorts now jockey for political economies of humanitarian aid.

A theme throughout many of these diverse approaches to medical pluralism in Africa is the dichotomous nature of etiology across healing systems. While anthropologists consistently argued against notions that patients are wholly adherent to one definition of healing or another—as CP MacCormack wrote in 1986, "if we take individual patients as the focus of analysis, we realize that there is already considerable informal integration of scientific and traditional medical systems," (MacCormack, cited in Olsen and Sargent 2017:2)— there remains an analytic split between "Western biomedicine" that seeks to identify specific pathological entities that cause

illness, and "traditional" medicine, which is often portrayed as interpreting illness as the embodiment of social tensions and realities (Lock 1988; Evans-Pritchard 1976; Turner 1981; Smith 2008; Stoller and Olkes 1989; Favret-Saada 1981; Foster 1976)). As anthropologist Lucy Mair wrote in the late 1960s: "All sick persons do not die; all persons exposed to an infection to not catch it; half a dozen people went up the ladder before it slipped and this one broke his neck" (1969:11). Attributing misfortune and illness to social realities, Mair noted, is a way of answering the fundamental existential question: "Why me? Why just then?" (10). Perhaps the woman withdrawing from the clinic without the malnutrition treatment for her child might be understood as indicting an epistemology of healing that effaced the primacy of the social in constituting health and care. The question of what "health" means in these conditions—and the ways that epistemologies of causation are enmeshed patients' affects and desires surrounding care—is a key theme throughout these chapters.

Recent ethnographies of medical pluralism in Africa have in many ways pushed forward Janzen's 1978 call to "open up" the study of healing systems, and now focus on the hybridizations, frictions and contestations surrounding diagnostic and therapeutic forms in healthcare systems. Stacy Langwick, for instance, describes how traditional healers in this postcolonial, neoliberal moment "take biomedical knowledge seriously without privileging its truth claims over other ways of understanding bodies and their variable states and without assuming the materiality of the body and those things that afflict it to be universal" (2007:90) and in the process tinker with modes of evidence-production, knowledge and appeals to scientific reason: implementing randomized trials on their herbal remedies, for instance, or testing out new medicines on rats (Langwick 2011:4). Today in Africa, one sees "complicated, interdependent therapeutic ecologies rather than... discrete differentiations of pluralist systems" (112) made all

the more complex through the proliferation of NGOs and other non-state actors in the aftermath of structural adjustment and the neoliberalization of global public health. A study of medical pluralism in Kono today, where the divisions between the magical and the medical, the traditional and the bureaucratic, the esoteric and the scientific cannot really be discerned, begs for an increasingly "kaleidoscopic" approach: granular, specific, attentive to novel relations and entanglements of actors, epistemic systems, political formations, languages and models for health and care (Olsen and Sargent 2017:3).

Beyond Rational Choices

These three lines of social inquiry—behavioral public health; anthropological work on the violence of care; and ethnographies of medical pluralism—all open up different dimensions of the calculus at play in people's withdrawals from global health care in Kono. But where, in some ways, they converge is in their recourse to paradigms of internal-consistency and -rationality. Public health researchers I have spoken frequently argue that, for instance, pregnant women in Sierra Leone have a strong cultural reliance on traditional home-birth attendants, and thus they frequently resist imperatives to deliver in public health facilities due to their beliefs. For Scheper-Hughes, the selective triaging-out of children makes internal and articulatable sense in the context of a social world in which food and life-sustaining resources are so sparse. Langwick suggests that scarcity in the biomedical healthcare system that has resulted from structural adjustment policies in Tanzania has in part created new interest in and openings for traditional medicine in therapeutic trajectories. She does acknowledge that patients' navigations through various fields of care do not always seem rational from the point of view of any one actor, but

the frictions she is interested in are contestations over epistemology, ontology; in other words, how people adjudicate and levy ways of knowing about diverse types of care and in the process translate forms of knowledge or even certainty (Langwick 2008:25). Cultural beliefs; conservation of resources; biomedical scarcity; "ontological politics" of therapeutic knowledge: while putting the onus for patients' relations to care on different sites, these models all suggest, at some level, that patients' decisions about whether to seek care *make articulated* and *coherent sense*, and that ethnography can make these rationales *legible*.

I do not reject these analytics, but am concerned with their limits for understanding the multivalent affects that coalesce as patient-subjectivities and thus patients' traversals through landscapes of care in a place like Kono. For one, belying much of the literature on medical pluralism in Africa, my interlocutors rarely express certainty about their decisions. They express mixed feelings, desperation, ambivalence; they tell stories of rapid swerves towards and away from certain types of care as new prospects for healing open up; or alternately a sense of going-through-the-motions, frustration, feeling stuck but not wanting to give up. My interlocutors at times even express confusion at their own decisions; or sometimes bewilderment at "what it all means." Scholarship that insists upon a representational "meaning" or rationale behind people's relationships to care, I find, often does not capture the uncertainty of this space of ambivalence amidst overwhelming contingency and the unresolved specter of death—when, as the *Krio* expression goes, "*what can you do, but try and manage?"*—a space in which, my ethnography reveals, many patients in Kono inhabit. I am drawn to explore precisely this space of uncertainty and non-knowledge, in which patients' investments in their own traversals through systems of care are fragile, born of impulses, desperations, and practice of making-do amidst it all, more than solid epistemic or ontological positions.

Theories of affect have recently influenced many domains of social analysis and critical theory, and emphasize that "visceral forces beneath, alongside, or generally other than conscious knowing" (Gregg and Seigworth 2010:1)—that is, subjective, embodied knowledges, experiences and feelings— are too often neglected by modes of social inquiry that depend on language, subjects' clearly-articulated motives or excavatable psychologies (Gregg and Seigworth 2010; Schaefer 2019). The premise of work by theorists like Lauren Berlant (2011) is that "the present is perceived first, affectively" (4). This perceiving, of course, does not tell the whole story. Historiography, psychoanalysis, ethnographic renderings of cultural forms, practices, epistemologies, and beliefs and political-economic analyses of social structures can all reveal configurations of power and patterns in people's behavior. Furthermore, affect theory's incorporation into anthropology has been critiqued as standing-in for rigorous empirical research, or making the object of study endlessly ethereal and inchoate (Beatty 2019).

But affect theory encourages us to dwell in political, cultural and historical processes as still ongoing, unfixed, and only crystallizing as real and concrete as they are lived through the interiorities of complex, contradictory people. What affect theory offers, in other words, is one way of engaging people and their behavior that does not consistently recapitulate the idea that there is a rational, articulatable reason behind it. This perspective is particularly helpful here as people in Kono encounter, remember and assimilate the arbitrariness of death and illness without necessarily making meaning out of it (a central concern throughout this dissertation).

Affect in Ethnographies of Africa

Berlant and Kathleen Stewart turn to Avant Garde art, political mobilizations, and evocative renderings of the affects of everyday life as methodologies for researching and writing how the swirling mix of history, culture, social life and discourse all are embodied as affect in the contemporary United States (Stewart 2007; Berlant 2011). These may not be the same empirical domains that apply to an ethnography of people's relations to care in Kono—and indeed, ethnography as a method attunes to real people's storytelling, lived histories, becomings and local social worlds in ways that critical theory and literary studies cannot just by virtue of the difference in empirical methods. In some ways, however, I have learned the most about how to write about affect from an ethnographic immersion in contemporary West African fiction, as well as an attunement to the stories—if not "objects" (per Berlant)— that people live by themselves (Neale Hurston, in Hemenway 1976:41). But I do also take inspiration from some recent ethnographies of Africa in which affect has emerged as a central object. Julie Livingston, for instance, writes of the *space of laughter and pain* in a Botswana cancer hospital, revealing something about how patients come to "know that something critical is happening to them….[and] into the breach of expression comes laughter" (Livingston 2012:151). James Ferguson describes the *abjection* conveyed in the letter two young African stowaways wrote to "Europe" before dying in the landing craft of the airplane on which they had tried to escape their lots (Ferguson 2006). Charles Piot writes of a general malaise in post-Cold War Togo, born of a *nostalgia for the future* (Piot 2010a). Celestin Monga writes of a vernacular poetics of *nihilism* that have flourished amidst the absurdity and violences of life in postcolonial Cameroon, where *négritude* never could (Monga 2016). Nancy Rose (2008) articulates a method of *aural* historiography of colonialism in Africa; that is, an attention to the *acoustics* of violent acts and events written into the archives, to the sounds emanant from atrocities but that also convey more

subtle traces of how life went on with *nervousness* amidst the "shrunken milieu" of colonialism: "the sounds of people scattering in flight, speaking in hushed voices, testifying bravely, remembering through stories marked by song, nicknames, poisonous images, and weeping (242)." The goal, according to Hunt, is "to seek more fragile, memory pictures and acoustic traces that tell us something new and more complicated about the immediacy of violence and its duration in memory" (230-231).

An ethnography of affects towards care in Kono would not hinge on the cognitive steps, symbols or delineated contests involved the woman's decision to withdraw from care for her daughter, to the everyday experiences—disparate ones, that at first may not seem connected—that make withdrawal from care feel the right thing to do in that moment. Throughout this dissertation, then, I pursue questions such as: How does a *gut sense* of the incomprehensibility of what the future holds come to inform what patients expect out of care? How do colonial political formations now lead to a certitude in the *opacity of intentions* underlying new regimes of global health care? How is the bewildering *arbitrariness* of landscapes of transient humanitarian care today reflected in people's inconsistent relations to hope, loss and the future? How do the stories that experts tell—stories that claim to reveal why people are ill—come to affect people's own sense of place in the world and relation to precarity and impoverishment? How might other sites of healing and domestic caregiving in Kono register these affects?

The challenge, of course, is how to write this type of ethnography. I try to capture and explore various domains of everyday life and care in which affects, imaginaries and dispositions towards care are engendered and affirmed. My specific interest is in the relationship between regimes of contemporary global health and peoples' affects towards care; thus, I spend more time in the healthcare system, in the way health politics appear to people on the ground, and in

patients' withdrawals from the healthcare system than in spaces of myth, religion, sodalities, or, alternately, agrarian practices, material culture, gender dynamics—all critical and relevant spaces of everyday life in rural Sierra Leone that have been extensively studied by others (Bellman 1984; Richards 1996; Ferme 2001; Shaw 2005). The Sierra Leonean civil war of course is a critical moment in Kono's recent history that I only have space to allude to at times, as it is evoked by interlocutors.

But even with a focus on the infrastructures of health and healing, I dwell less on the technical and expert-reasons underlying regimes of global health, and more on the "suffusion of the ordinary with fantasy" (Berlant 2011:14) in Kono's rural health system: in the dreams people have about the types of care that are possible and what will get them to that care; in the ways in which failed promises about people's access to care create a condition of *sensed* crisis that does not preclude future optimisms but also produces certain kinds tolerance; in how people's knowledges of health politics in the present in Kono do and do not make sense of the mystifying "arbitrariness and intrinsic unconditionality" of the postcolonial condition (Mbembe 2001).

I suggest, for instance, that one cannot apprehend why refusal of Ebola care would make sense without spending time immersed in the ways that diamonds so whimsically alter life-chances in Kono, for better or, more often, for worse; that pregnant patients' skepticism towards obstetrics clinics must be portrayed in relation to the ways that the despotic authority of Paramount Chiefs has been mystified by colonial structures of power and is now harnessed by NGOs. I assert that one cannot begin to parse what "refusing" healthcare feels like without understanding how the vacuous discourse of neoliberal public health has penetrated even a group of so-called "Traditional Healers," obfuscating the forms of care they offer. I stress that one must situate violent riots against Ebola responders within a landscape of power in which all politics

comes to seem spectacle, distant, untethered from the stakes of people's own living or dying. And in all cases, I emphasize that one cannot take for granted the expert reasons, consistencies, predictabilities, uniformities or even presences of transnational health institutions; that global health care is *made real* in Kono at a "meso-level," in on-the-ground infrastructures and relations of care with whom patients encounter and interact (Biehl 2016). In some chapters, I engage and attempt to describe head-on the affects at work, drawing both on my interlocutors' stories and, often, West African literature. In others, I describe the political and structural conditions that might play a role in conjuring these relations towards care: for instance, the deep cynicism engendered by the close relations between neocolonial extractive corporations and local political authorities who are tasked with managing health crises. There is no empirical start nor end to this type of project, no ethnographic frame big enough, to "answer" these questions. But with an expansive ethnography that spreads out, I try to track the ways in which these disparate events, situations, histories and languages transform into affects.

Throughout, I follow individual patients, health workers and healers all pursuing their own "lines of flight" (Biehl and Locke 2010)—making sense of their precarious therapeutic worlds, sometimes trying to transcend them, but often facing them with a kind of stoic impassivity and retreating to more intimate forms of living and dying beneath the claims, spectacles and optimisms of global health and care. I am drawn to writing these individual characters (iconic, each in their own way, of this era of global health) both because, as a method, I find people's own engagements with particular politics of care, the ways they may extend them to their extreme conclusions, embody them in other domains of life, or alternately push against or beyond them, a helpful way of thinking about how people the world over theorize the structures to which they are subject, unwittingly or wittingly. This is a way, in other words, of

thinking beyond notions of structural violence, political formations or even structures of affect as all-constraining, and to what has been called the "becomings" and "plasticities" of subjects facing foreclosed futurities (Biehl and Locke 2017). To borrow from historian Carolyn Steedman, who writes of the inherent frictions in trying to articulate subjects' shared affective conditions born of histories, economic constraints and politics, while also attending to the singularity of individual subjectivities and psychological lives, my goal in writing of shared affects towards care is not: "to find a description that can be universally applied (the point is *not* to say that…all are the same, nor that [this particular] experience produces unique psychic structures) but so that [my interlocutors]…may start to use the autobiographical 'I', and tell the stories of"—and, *I* might add, ethnographically theorize—"their life" (Steedman 1987:16).

Beyond an Anthropology of Ruptures

At times, people's withdrawals from regimes of global health take the form of outright eruptions and tensions. This was particularly the case during the Ebola outbreak, when "community resistance" to healthworkers was widely cited as one of the key drivers of transmission. In these moments, frictions in the politics, beliefs, epistemologies and affects towards care are made particularly visible. A great deal has been written about "resistance to care" in Sierra Leone—particularly vis-à-vis Ebola—and here, the anthropological tendency in accounting for these acts of resistance has been alternately to home in on those moments of outright clash, situate them in a broader sociohistorical context, and explain their internal rationality (another recapitulation of the "rational-choice paradigm") (see, e.g. Abramowitz 2017), or to allude to abstractions like peoples' "lack of trust" in Western medicine as if *trust* is some kind of free-floating, organic

substance in the world rather than a complex set of mixed-feelings and affects (Richardson et al., 2019).

Such ethnographic knowledge can indeed be very helpful galvanizing more humanitarian concern, highlighting the structural causes of peoples' poor health and their skepticism towards healthcare systems, and may also be actionable for those seeking to design *better* global health programs. But remaining in the realm of the rupture when studying the frictions surrounding peoples' engagements with global health interventions may preclude other types of ethnographic attention: that is, to a temporally broader milieu of politics, history and affect that underlies social life in moments of health crises and periods of more ordinary precarity alike. As Berlant writes, "the genre of crisis can distort something structural and ongoing within ordinariness into something that seems shocking and exceptional" (Berlant 2011:7). While many anthropologists have alluded to the ways that "resistance to care" in Sierra Leone is born of longer histories of marginalization, distrust and violence that are embodied in the ordinary (Benton and Dionne 2015; Allouche 2015; Carrión Martín et al. 2016; Abramowitz 2017), few have linked these historiers to quotidian experiences to explore how moments of crisis may be experienced as the escalation of the everyday challenges of life and care. Such an approach would pivot one's methodological tack from genres of meta-history or analyses of expert discourse alone, to a historically-grounded ethnography of the meso-level, on-the-ground infrastructures, people and institutions in which those histories are made concrete in real people's lives, and where, as Joao Biehl writes, "people and the worlds they navigate and the outlooks they articulate are more confounding, incomplete, and multiplying than dominant analytical schemes tend to account for" (Biehl 2016:77). Indeed, when one actually follows patients in hospitals, HIV clinics or even Ebola hot-spot communities in Kono, patients' trajectories through care and what has been

characterized as their "resistances" seem more adequately described as *swerves, plateaus, collisions* and *withdrawals* towards and away from the healthcare system (terms developed in chapter 3) than calculating decisions about healing systems or outright "rejections" of care.

Additionally, ethnographic research on people's relationships to care that takes as its *a priori* object a field designated by the global health juggernaut—for instance, "HIV patients," "the rollout of ARVs and non-adherence," "the Ebola crisis," "cultural beliefs confounding efforts to encourage women to deliver in clinics,"—may miss the ways that that very juggernaut and its propensity to delineate fields, crises and objects may have played a role in producing the frictions therein. This is precisely my interest.

In other words, an ethnographic emphasis on delineated eruptions of resistance may miss the threads of affect and experience that connect, for instance, a mother who returns home without readily-available food support for her malnourished and dying child and to a man who knew he had Ebola and yet quietly remained at home and spread the disease to his wife and daughter. Eschewing models of crisis and rupture may open up spaces of "wondrous" (Hunt 2016) and "fugitive" (Moten 2008) possibilities among subjects who are often portrayed as abject and helpless, but not necessarily. For while my interlocutors do tell stories at times of moments in which they overtly and violently resisted public health efforts, they more consistently narrate their withdrawals from care through a quieter register of intimate storytelling, and connect it to a broader experience of living in a world filled with arbitrariness in which a great deal of politics and claims of care must be met with skepticism. In attending to this quieter rather than spectacular register of withdrawal, in other words, one is drawn more to the dissonance or mixed feelings conveyed by these stories than, necessarily, the isolated moments of outright avoidance of healthcare services.

Sierra Leone

Sierra Leone, a small circular country on the southwest coast of West Africa, has a dizzyingly complex modern history as a staging ground for entangled projects of European colonial expansion and humanitarian initiatives. European contact began in the mid-15th century, and the region later was a center for transatlantic slave raiding and trading. In 1787, even before the British had banned the slave trade, the Crown founded a small settlement called the "Providence of Freedom" for poor blacks from London, some of whom had been liberated in the Americas by British troops during the Revolutionary War. This was the first humanitarian-sponsored "Free African Colony" just twenty miles from the Bunce Island castle from which para-statal British companies continued to ship African cargo to the Americas. Though this initial attempt to colonize failed due to the extremely high mortality rates from malaria and harassment from local chiefs (likely under the sway of the slave-traders upriver), five years later a second attempt at settling the area was carried out, with 1300 loyalist former slaves who had been living in Nova Scotia (Banbury 1889:59-60). Over time, as more freed Africans settled in Freetown from the Americo-Liberian settlement nearby, these early settlers adopted Western names, styles of dress and sought to build a city in the image of a European cosmopolitan, educated metropole, and together became known as the Krios. Thousands of Africans "confiscated" from slave ships after the trade was banned were also resettled in Freetown.

The British colony expanded to a Protectorate in 1896 that included Kono. In 1961, Sierra Leone was granted formal independence. From the late 1960s to the mid-1980s, the country was ruled by strongman President Siaka Stevens and suffered the beginnings of the

postcolonial economic collapse (described below). In 1986, the country received its first Structural Adjustment loan which led to further collapse of the country's public services. The bleak economic prospects in the country, marginalization of rural youth under postcolonial systems of rural rule, and political excesses and graft often derived from the diamond trade set the stage for the 1990 – 2001 Sierra Leone civil wars.

Kono District—in the far east of the country, on the border with Guinea—is a deeply impoverished region that has also long been the center of Sierra Leone's diamond trade. The indigenes of the region are Kono-speaking, though several Chiefdoms are predominantly Kissi. Nearly all public infrastructure in Kono was destroyed during the war. The bombed-out ruins of wealthy diamond traders' homes and shops continue to dot the main roads through town (now often turned into people's living spaces with tarpauline roofs and zinc-leaf doors). The Government has only recently restored somewhat-reliable electricity for a few hours a day to Koidu, and, until the highway was reconstructed a few years back, it took nearly all day to reach Kono from Freetown on rutted roads. Several international health and development NGOs have large presences in Kono. But since Kono is not a reliable source of support for either of Sierra Leone's main political parties—the "*Ohio* of Sierra Leone" as I have often heard it described, the swing state—people in Kono are quick to explain that this is a deeply neglected part of the country. After elections are over and political parties are firmly in power, the promises of directing development projects to Kono are quickly reneged.

It is always startling to hear a young man in Kono tell me that: "We are wicked here, we don't care—you the whites are the only ones who care for us," or, as often happens when talking with people in Kono about the source of their region's impoverishment, an interlocutor holding up her hand: "You see that the middle finger is higher than the rest? It is the same with the races:

you whites are more developed than us." Indeed, I have rarely heard the region's histories of colonial violence, postcolonial-imposed scarcity and extraction voiced by my interlocutors in Kono. One reason might be that with a life expectancy so low, history is lost more quickly by the serial generations that come and go. In the twelve years that I have worked in Kono, almost all of those who had been the family heads and sources of stories and histories have died. But in addition, the historical particularities of British colonization in Sierra Leone—and in particular, the tensions (in part stoked by the British) between Protectorate indigenes and Krio elites which enabled the British to skirt anticolonial ire— have also made this a deeply politically moderate population.[5] While there was certainly a history of Trade Union organizing and (sometimes violent) protest against perceived injustice (against British colonial administration and against extractive corporations today)[6] my interlocutors rarely link their present conditions to histories of colonial extraction or ongoing political-economic arrangements, and instead often blame the "mindsets" of Sierra Leoneans and its citizens' propensity for corruption. This, I believe, is partially why the overwhelming frustrations with humanitarian global health in Kono that I attend to throughout are rarely articulated as outright politics of repudiation or refusal. Africanist scholars like Achille Mbembe and Mahmood Mamdani have explored various reasons why grassroots political overhaul or true democratization movements have been so elusive in much of postcolonial Africa (Mbembe 1992; Mamdani 1996). But the particularly politically-moderate

[5] For instance, with little funding for or mandate to develop public infrastructure or educational institutions in the interior, outsourced governing to a select group of what became called Paramount Chiefs. Frictions between the rural indigenes and the cosmopolitan Krios in Freetown emerged as the central tension throughout the 20th century. These tensions were stoked in part by the British colonial government whose educational and governance systems emphasized identity-politics in the hinterlands and which led conflicts with the cosmopolitan Krios. All of this enabled the British to largely skirt major, grassroots anticolonial resistance, and the British had to usher-along a rather reluctant Krio elite to decolonization. For more information, see (Cartwright 1970; Wyse 1987; Corby 1990; Bergner 2005; Cole 2013)

[6] The Sierra Leonean civil war has also been characterized as born of a resistance to the forms of rural governance developed during the colonial period that have persisted to this day. (Richards 2005)

history of Sierra Leone and the ongoing erasures of colonial history and critiques of neocolonial forms of power (for reasons more explicated in Chapter 1 and Chapter 4), make Sierra Leone's political predicament exceptionally entrenched. I have been left rather pessimistic about the possibilities for a more radical political leadership that could stand up to the forces and health and financial institutions inflicting ongoing structural violence on the country.

Palimpsestic Memoryscapes and Humanitarian Petri Dishes

While histories of colonial extraction are not a topic of frequent conversation in Sierra Leone, there are other modes through which memory sediments in a place like Kono, and this has been a long point of anthropological interest: from ways that people read the forest landscape attuned to the existence of abandoned historical settlements and now-buried colonial villages (Ferme 2001:25), to occult and ritual imagery that has been shaped by the violence of slave predation (Shaw 2002a), to the many ways people narrate their experiences during the civil war or the Ebola epidemic—as traumas that should be spoken to memorialize and transcend, or, alternately, kept silent, forgotten or not thought about (Shaw 2005; Richards 1996; Bolten 2012). Anthropologist Paul Basu (2007) terms the landscape of memory-forms in Sierra Leone as a "palimpsest memoryscape," implying that historical memory in Sierra Leone takes form less as a set of hybrid or "creolized" memory-forms, and more remains a terrain of co-existent modes of remembering, such that such that "one period [may be] remembered through the lens of another" (234; see also Vansina 1974).

I find the palimpsest a helpful image to describe these accreted lenses of memory. But this is not some spontaneously-arising landscape of plural memory-making. Rather, this

particularly layered (and at times discordant) memoryscape has, in part, emerged because Sierra Leone has been such a ground zero for humanitarian regimes of intervention and projects (the waves of "butterflies," so to speak) involving varying forms of reconciliation to transcend violent pasts for centuries. Sierra Leone's "founding" as a colony for resettled slaves inaugurated a certain utopian political imaginary that masked more extractive colonial politics at work (such as the creation of new markets for British goods) (Scanlan 2017), for instance. These ways of remembering have continued to be instantiated via humanitarian projects like those that aim to encourage HIV patients to publicly proclaim their diagnoses in order to assuage their stigma, while doing nothing to address those patients' food insecurity (Benton 2015)—among others. These histories of humanitarian politics and intervention accrete on top of each other, forming landscapes of tropes, modes of discourse, confessional technologies (Nguyen 2010), claims about how to live, understand history, remember, transcend and care—often without doing much to really remove the threat of capricious disease and a sense of the arbitrariness to death in the region.

These sedimented strata of memory-forms, to extend the archeological metaphor, are not equivalent in depth (Basu 2007). This is crucial for understanding the relationship between Sierra Leone's palimpsestic memoryscape and how it comes to colors people's relationships towards regimes of humanitarian care. Take the following example: the Tankoro Chiefdom Paramount Chief, a man who will appear throughout these chapters as a local big man, broker of health aid, and mediator for an international diamond mine rapidly expanding throughout the region. Sometimes, when I have asked people in Kono about him, I have been told about the precolonial history of the Paramount Chieftaincy. A pastor once told that while this particular chief had made some bad decisions, the family had ruled for time immemorial, this is how the system

worked, he came from a chiefly household. My closest interlocutor David once remarked that he had always thought it interesting that the Kono word for Paramount Chief was *Gbɔ Maansa,* meaning "Paper Chief." At some point, the British must have meddled in this leadership role, replacing a "staff" for a piece of "paper" signed by the Provincial Secretary. (More on this convoluted history in Chapter 1.) David was certainly not ready to overhaul or abandon the role—he flirted with Chiefly aspirations himself—but he had a certain skepticism at its supposed indigenous authenticity. A young doctor I met, himself from an important political family, said he didn't know why everyone was so mad at the Chief for all the havoc unfolding in Kono over the last two decades: this was a political role, parallel to the National Government and endorsed by the British development experts in the post-war era, and decisions were made that were above the Chief that he had to enforce.

But most people I have spoken to who live in the communities that this Chief worked to displace alongside the mining company say merely: *that man is wicked.* He "chopped" *mɔni* during the war and after, in cahoots with the mining company; he chopped *mɔni* during the Ebola outbreak when he oversaw the epidemic response; he's always chopping NGO *mɔni* as he serves as the gatekeeper for humanitarian organizations seeking to work in his Chiefdom. This recent layer of history, in other words, is what has the most bearing over peoples' current political imaginations and futurities.

The stories that follow convey just how much this recent landscape of humanitarian and global health care—that mix of NGOs and health messages, transient sites of life-altering services and political economies of health resources and aid, and discursive tropes, all entangled with local politics and economies of extraction—saturates this part of the world. But, the subtle ways that my interlocutors shift their retelling of memories of violence, epidemics and death,

from speaking the language brought by humanitarian regimes of care that persistently centers Sierra Leone's own behaviors as overdetermining their health, to one of a quieter, more personal disposition of skepticism, of holding their living and dying close in what comes to seem overwhelmingly arbitrary world, suggests that this layered memoryscape may in fact be a part of what alienates subjects from the possibilities of care. In other words, there may be another milieu of experience, memory and embodied history at a level *beneath* the palimpsest that is reflected in peoples' relationships towards care. Ultimately, I am interested in what this milieu might reveal, lurking beneath the residues of interventions, discourse, the clinical, political and maybe even the symbolic.

Chapter Overviews

In Chapter 1, *The Postcolony and the Mine,* I dwell on the nature of contingency in Kono and the never-quite-adequate capacity of religious cosmologies to assimilate it. With a similar attention and set of questions, I then shift to the inadequacies of local, semi-colonial political systems to mitigate the life-altering exigencies resulting from the diamond mining industry. I draw out the resonances between peoples' dispositions of skepticism within these two domains—the religious and the political—towards whether material/economic or emotional/existential security or stability can every really be achieved or maintained. Through ethnographic vignettes at three different scales (mid-range foreign actors who circumvent regulatory systems to indiscriminately demolish infrastructure, houses and farms; a massive industrial mine that is using colonial-era tactics to reclaim and destroy inhabited land; and small scale Sierra Leonean miners who spend every day shoveling through gravel looking for a life-changing stone), I consider the random,

world-making and -breaking possibilities of the diamond mining industry, and the ways in which my interlocutors oscillate between states of intense resistance, purpose and meaning with ones more akin to impassivity, alienation and futility. I end with a consideration of how small-scale miners in Kono narrate their relationship to the land and possibilities for a more-stable future. I explore the ways that discourse, life-histories, stories and even magical practices involved in increasing one's "luck" in the diamond trade are narrated with a structure of affect like that which Lauren Berlant calls "cruel optimism": juxtaposing the promise of mid-20th century prosperity when the diamonds were flush with the seeming randomness of who is able to transcend an existentially-precarious everyday today.

In the interlude, *Illusory Global Health,* I briefly recount the historical and geopolitical contingencies that have led to the "republic of NGOs" and the global health era in Kono. In contrast to critical global health scholars and anthropologists who have framed the rise of development expertise in the wake of structural adjustment as advancing a coherent, if problematic, neoliberal agenda, I suggest that the global health that actually materializes in Kono is often constituted by obviously-nonsensical, inconsistent, performative and vacuous regimes of care. I explore the emergence of a "Global Health Class" of enactors/subjects of these regimes of global health in Kono, who now navigate fleeting economies of humanitarian resources and employment, and astutely reflect on their "arrogantly assertive" (il)-logics (Lachenal 2017:13).

Chapter 2, *Supervising Life,* I weave together stories from the Sierra Leone Traditional Healers' Union, a group of local healers whose bureaucratic ambitions reflect WHO aspirations for integration of plural health systems. I trace how a labor of *imagining* idealized health bureaucracies ripples from the WHO to Global Health Security workshops to the ways local healers organize and orient their effort, probing what to make of these many mirrors, all of which

begin to appear as merely discourse and imaginary with little bearing on the actual therapeutic trajectories of their patients.

In *Chapter 3: Mɔtalman*, I recount the stories of patients with chronic, debilitating diseases who have returned home from sweeping journeys across the country to many sites of humanitarian care. I explore an orientation towards extreme suffering in Kono that frames it as existential, shared and beyond meaning. I consider how patients' experiences of exclusion from the healthcare system may engender an existential reading of their own bodily debility, precluding the possibility of imagining bodily restoration. In a place in which chronic physical debility is experienced as a central experience of everyday life, and in conversation with recent critiques of theories of disability rights and justice, I consider how patients in Kono may inhabit a manageable *plateau of tolerance* as they build domestic lives and futures in the wake of withdrawals from care.

In Chapter 4, *Seen but not Meant***,** my interest is in how critical theories of postcolonial African political formations— and an attention to a landscape of West African politics "wired for dramaturgy" (Piot 2010:19; also Comaroff and Comaroff 1999)— may offer new ways of attending to the particular forms of intervention that unfolded in rural peripheries, as well as people's ambivalent relationships to transient waves of humanitarian incursion that are often experienced as spectacle, devoid of substantive care. I focus on three moments of tension and violence during Kono's Ebola outbreak to consider how the spectacle of serial humanitarian incursions become enfolded into what Achille Mbembe calls the "aesthetics and stylistics" (Mbembe 1992) of political power in the West African postcolony. I conclude by returning to the stories of Ebola survivors in a "hot-spot" village in Kono that reveal more quotidian experiences of skepticism, uncertainty, living and arbitrarily dying that underlay what has been called

"community resistance to Ebola care," and to consider how the tensions amidst health crises like Ebola may be encountered (and enacted) as the escalations of the ongoing challenges of postcolonial life and care.

Chapter 5, *Conjuring Global Health Security*, brings readers to a remote clinic in the forest where Ebola first emerged, and considers the centrality of global health security and epidemiological surveillance as key priorities for the Sierra Leonean health care system after the Ebola outbreak. Amidst this broad shift from conceiving of clinics as sites primarily for the provision of therapeutics to instead sites for disease surveillance and threat mitigation, paperwork regimes have proliferated within remote facilities that are out of stock of nearly all supplies and unable to address even the most basic of infectious diseases. I describe one nurse named Tamba whose endless paperwork tasks seem to have transformed into a type of magical therapeutic practice, resonant with other forms of local text-based healing. Drawing on the logic of the text-feetish, I explore how this latest phase of global health expertise and implementation mystifies and circumvents the ongoing material causes of the region's vulnerability to epidemic threats.

Chapter 6, *Tamba's Medicine*, engages this same clinic as a site in which the economic, cultural, religious, interpersonal, magical and clinical come to intersect. I probe "what" patients withdraw from when they leave the healthcare system. As Tamba deftly navigates these various epistemologies and systems of healing, politics of global health and interpersonal tensions, I gradually become uncomfortable with the experimental nature of care that I witness. Drawing on a *bricolage* of pharmaceuticals he has cobbled together from informal supply chains, physiologic imagery, medical fantasies and magical explanations, this clinic's nurse, unsupervised but beloved by the surrounding communities, is practicing dangerous medicine. I dwell on the

question —*what kind of care is this?*— as I come to learn that many if not most patients ultimately withdraw from his services. I explore these withdrawals through the lens of affect to capture the frustrations of regimes of care that relentlessly promise improvement without changing the material and ongoing threats of death in Kono.

Chapter 6, *Bad People* follows a new charismatic healer in Kono and two of his patients as they bounce, ambivalently and inconclusively, between sites of care. Their meandering stories and desires—with the backdrop of Sierra Leone's further descent into political and economic crisis— open up concerns about how health, care and cure may be envisioned amidst a broader condition of living and dying in the wake of colonialism, violence, neoliberalization, and ongoing extraction.

Chapter 1: Contingency, The Postcolony and the Mine

> Greetings dear I have lots my younger brother Solomon😭😭😭😭😭he got into a car accident this morning😭😭😭😭😭
> He was washing his mouth very close to the door and the driver road on top of him😭😭😭😭😭
>
> ***
>
> Little bit challenging my mom is in trauma right now because of the situation that happened🤦
> I am just trusting Almighty but it's not easy for me this month, my mom and I together with my siblings love Solomon so much😢🤦

I woke up to these messages from Peter, a young man I knew from Kono, last November. Peter, in his early twenties, had a baby-like face that sat awkwardly on a squat and muscular body. No doubt an odd character, he was the only one of the boys who used to hang around my house in Kono who would run up to give me or whoever else was arriving at the end of the day a hug, and he loved following the American NGO workers' yoga routines. The other boys from his school used to tell me that he acted nice, but when you looked at his body you saw what kind of upbringing he had in the village—no shoes, working in the bush at a young age, stunted from the lack of food. They said that he was a fearsome fighter when provoked. Peter described his childhood as having "no better fatherly love."

Peter lived near my house on the outskirts of Koidu in a hovel that his father had rented before he left Kono to find money and did not come back. Recently, the various American volunteers with healthcare NGOs that Peter had met chipped in the few dollars a month to help him with rent. Peter did not have many friends; his spacey and abrupt questions and awkward sense of humor led the other kids to poke fun of him frequently. I remember the day I was in a conversation with a colleague and Peter raised his hand, and asked: "Excuse me, Raphi, but I just have one question: 'Does garlic have protein in it?'" Everyone around roared, and I couldn't help

laughing a bit myself as I tried to figure out what had prompted his line of thinking. “I was just thinking about it!” he said. David, my friend and assistant who was listening from the corner, just shook his head and said that too much time on social media had made the younger generation’s thoughts completely confused.

Then, as happens to many of the young men in Koidu who do not have a footing in any particular work and who have migrated to urban areas away from their family villages, a pastor came by Peter’s house and invited him to a new Pentecostal church in the neighborhood. Soon, Peter declared himself “born again” and the church consumed his time. Almost every other day he would walk by my house as I was eating breakfast, coming home from all-night prayers at the church’s branch in town. He began to dress in tucked-in Oxford shirts and slacks, walking around with a backpack stuffed with a Bible and other notes.

Peter attended secondary school in Koidu and liked to tell me about his shifting ambitions for what he hoped to do after graduating. His ideas must have come from the books he looked through, but it was hard to tell how he related the possibilities. He declared one time that he wanted to go into “airfield management,” but could not really explain what that would entail nor why. In moments like that, as well as when he asked that question about garlic, I could not follow how he related his own (inquisitive, ambitious) interior life to the questions he spoke. In any case, he never could pass the secondary school exam, and during the latest attempt was hoodwinked by someone at the exam council’s regional headquarters. That year, his entire school’s exam scores had been cancelled because of the rampant cheating and conspiracies between the students and teachers (there was a collective price-per-question-tip system). Peter went to Freetown to beg the men in the office there to release his score, and to offer them a tip. “The man looked at me and said, ‘I know it is so, so hard to be a student out in Kono, with the

state of the education system there," Peter told me. "He said, 'It is not fair to you, but we should care for each other, let me see what I can do and help you.'"

It did not seem like Peter had fully thought through the intervention the man had made, nor that it might be considered a transgression. He returned to Kono with a score-sheet so outrageously perfect that when he presented it at an NGO office for a job, the human resources officer shrugged and said: "Look man, these are fake scores!"

The Accident

Peter cared deeply for his mother, and especially for his four-year-old brother Solomon. His mother and brother had recently moved to Koidu from their family village where his mother made only sporadic income from a "pepper garden." It was at the old concrete compound where his mother had found a room to rent that the accident happened. His mother brought Solomon, Peter's four-year-old brother, out early in the morning to brush his teeth, and noticed a man with a vehicle loading up his car. The man asked for some water to pour into the coolant tank of his vehicle. She passed the pitcher that Solomon had been using to wet his toothbrush to the man. She left Solomon squatting on the steps of their house brushing his teeth, and, once inside, heard the man start the engine. She heard a rev, and then a loud bang. She thought, "That's strange." She turned around, saw her son's "brains splattered all over her compound," fainted, and woke up sobbing in the hospital.

Even in a region in which one in five children die before age five, in which the wailing of mothers running through the town after a child has died seems sometimes like the constant sonic backdrop to everyday life—and even for two people (Peter and his mother) who were no

strangers to misfortune and tragedy— this particular death stood out as obscene. I have seen several children hit and killed in Sierra Leone by overcrowded *poda podas* with shoddy brakes—they often do not stop to avoid the *fracas* that inevitably ensues—so this is not a wholly unusual cause of death for a young boy. But Peter kept emphasizing the horror of the fact that this occurred on his mother's very doorstep, the brains splattered within her own house—within *Solomon's* own domicile, that one shared space where such accidents are not supposed to happen.

The threat of death hangs over every child in Kono, thus it is a cliché, and not necessarily reflective of the temporality of family life and relations, to say that Solomon represented *the future* for Peter and his family. Nevertheless, Peter had staked a great deal on Solomon, was proud of him and certainly excited to see him grow up. He had begged me to visit Solomon each time I was in Kono and sent me photographs frequently of the boy. Solomon was a kind of grounding object of affection for a young man who did not have many friends outside of his church and amidst the precarity and turmoil of everyday life.

After the accident, Peter told me that he had traveled back to Kono from Freetown, where he had been studying at his Church's central compound, to pick up his mother and bring her to Freetown to support her while she was in what sounded like a catatonic state. She couldn't stop thinking about her son, couldn't sleep, couldn't allow herself to believe he was gone, Peter told me. She kept staring for hours at the spot where she had seen Solomon's brains scattered—that is why Peter knew he had to take her away, to convince her to stop dwelling on the accident, to stop *thinking too much*[7] and accept that he was gone. Peter told me that he Googled: "What to do

[7] This is the phrase that psychosocial researchers and NGOs have told me is an idiom for post-traumatic stress. Peter's recollection of his mother's state to me was clearly reflective of the models for traumatic memory that he had been exposed to in workshops, school programs and other health campaigns surrounding the end of the civil war.

with someone who is mentally disturbed after trauma"—and learned from the internet that he should just listen, nod, and not overwhelm her with his own emotions. What she really needed, Peter said, was some "proper counseling to overcome so much trauma."

I was in Freetown about a month after Solomon had died and made the trip to the outskirts of the city to a scrubby field where Peter's church was building a new compound. Peter met me on the asphalt highway, hugging me awkwardly. He was serving as an "Interceder," studying scripture and helping with the Crusades the church held frequently in the central stadium in Freetown. He said he was happy where he was now, in such a "community of disciples," but when I asked if he had enough food he shrugged and said he was content with eating dried *gari* (cassava dust mixed with sugar) once, or maybe twice, a day. Such asides conveyed the degree of deprivation Peter had experienced growing up and to which he had become accustomed. We walked through the blistering heat to a simple house, where I found his mother looking at the floor, in front of an audience of three or four neighbors, beginning to tell the story of what happened. There was a kind of fast-clipped rhythm to the way she spoke looking at the floor, as if from script, which compounded my uncomfortable sense of being an audience member to the emotional aftermath of such a horrific death. I wondered how many times a day she told the story, or if she had started recounting it for me to hear. At the end, I expressed my condolences, my friendship with the family, discretely gave Peter a wad of bills to pass to his mother later, and left to walk around with him outside.

Peter told me that the police in Kono were trying to charge the driver for involuntary manslaughter, though as an automobile owner with presumably some social capital the man was trying to use his influence to get the charges dismissed. Neither the man nor his family had offered substantial apologies. Peter said that he had visited the man while he was briefly detained

at the police station to ask what had happened, and the man had not responded. At first, Peter said, his mother wanted the man to be imprisoned or even killed, but now she and Peter both wanted to let the Government decide—more an admission, I thought, that there was no way the driver would end up charged and convicted with a crime. Peter told me, as if this was a normal escalation of things, that the driver's family had accused Peter's sister of trying to sneak in a vial of poison to the police station (presumably in order to kill the driver), leading to an argument in which the deck seemed further stacked against Peter's family. Peter and his mother had decided that they should: "Let God deal with it, it doesn't do anything to us if the driver gets thrown in jail for life." This seemed both a reasoned conclusion and a way of admitting of the impossibility of any type of justice for Solomon's death.

*

Peter had been one of many children who came by the Ichende International house each night over the years. The "Lodge," as it became known in town, was one of the ways that the organization was distinguished from the other NGOs in town, which cloistered their few ex-patriates behind concrete walls and tinted Land Rovers. Dozens of boys and girls, age five through twenty, would come by each night for the massive vats of rice and stew that the Americans staying there—researchers, visiting clinicians, college student interns, volunteer staff—would chip in a few dollars for each night. The children would get food and listen to music and dance, and the conversations that would open up between volunteers and Kono youth were at times wonderful to watch. A former US Navy captain helped a Pentecostal teenager study for the secondary school exam; a medical resident read each night with a ten year old boy;

a college senior from inner-city Philadelphia and a group of similarly aged young men talked about the differences in how businesses operated around the world. Discussions ranged from: what is it like to be an immigrant in America? What are your *secret societies* like? But here we hear that it is so simple to be rich in America—are there not poor people there? What is love like over there? Tell me about your political situation? In Kono, a place where so many interactions are underscored by such extreme and troubling disparities in wealth and power, there was something touching about watching this intersubjective curiosity and mutually storytelling unfold.

Not that these conversations and burgeoning relationships, however, were not also a part of peoples' strategies for survival and sustenance. The American volunteers and visitors often developed particularly close relationships with individual children, and, after weeks or months of getting to know them, quietly asked me or one of the other organization's staff if they might be able to support the child's education or food for their family. The Sierra Leonean staff created a system for disbursing these funds—after all, nearly all of the children in the village were chronically hungry and they were often driven from classes for unpaid lesson fees. The sheepishness with which the volunteers would ask how to help, and the real desperation that the kids often faced, belied a simple rendering of these relationships as born of the "White Savior" complex (see, e.g. Cole 2012). But the impact of these relationships were varied; some children from deeply impoverished, rural families went on to college and stable jobs; several others, to my great discomfort, seemed so affected by the disjunctures in worlds between those which their families inhabited and those of the Lodge and the elite schools they had been sponsored to attend that they became truant, delinquent or even criminal.[8] Some of these children absconded entirely

[8] One boy was accused of such serial and violent theft of expatriates, family members and other relations that he was basically driven from the region.

from their families and kin and became known as “bad boys” because, as people would say around town, the children had gotten too used to “living beyond their means” with the NGO volunteers. Ichende wound down the offer to help volunteers support new children after it became clear that the social and psychological forces unleashed by these somewhat arbitrary flows of life-altering resources were too complex—and not appropriate— for the organization’s staff to anticipate or manage, even as the kids in the surrounding communities, propelled by the stories of their friends who had found school fees at the “white people’s house,” kept coming.

Peter was never so successful at tapping into this bizarre economy of expatriate emotions and sympathy. Volunteers had told me they were put off by his strange questions and earnest but melancholic tone. But Peter had collected quite the contact list of past American volunteers he had gotten to know, and he had written them all on WhatsApp and Facebook periodically with updates from his life. The day I met him in Freetown soon after Solomon’s death, he showed me his phone: each message that described the accident and asked for help with food for his family was marked as “read” by the recipient, but there was no response from any of the American doctors, nurses, students, journalists or other volunteers—people that Peter had met through both chance and carefully curated collisions.

As I scrolled through what appeared like a diary sent to so many Americans, I wondered what type of lifeline these unanswered messages offered, and if they resonated with the religious vocabulary for contingency and the collective, ritual structure his Pentecostal church offered. Was Peter writing to Timothy and James in Chicago, or something more ethereal? Did he really think the Americans would send money or offer to help after so many years of silence, or was there some comfort that they *might* intervene if things got bad enough? Peter’s more pertinent world was in Sierra Leone, and I knew he overwhelmingly drew on kin, neighbors and his

church community for material, religious, personal, psychological and existential support through these crises—these were more relevant sources for care than the fleeting, though possibly life-changing, relationships with wealthy foreigners, myself included. But I wondered, as he sent message after message describing Solomon's death, what he made of this knowledge—at once hopeful and at the same time painful— that people out there, in an unimaginably affluent world, were at least reading and thinking for a moment of Solomon's death and the further dissolution of Peter's world.

As we walked around the church's compound, I asked Peter if Solomon's death had strengthened or challenged his religious convictions and life. "It has strengthened my faith," he answered not missing a beat. "It's another test among all the troubles I have had." He said he did not know *why* the driver did it—maybe as some kind of a sacrifice for a witch, maybe because he's just evil, but maybe it could also have simply been a mistake.

After listening, I added: "At least Solomon didn't suffer. It was fast." Peter looked confused, like he had never heard anyone say something like that. I explained that people in America often say they hope for a quick death, without suffering. He said: "I don't hope for anything like this for anyone."

"What do you think made this happen?" I asked.

"God's plan."

"Does that make it easier to bear?"

Peter thought about it, shrugged, seemed to convey—a little bit yes, but not really.

I recalled all the many times Peter had referenced "God's plan" to me. When he described his upbringing in the village, hungry, with no parental love, working long days in the bush and no school. "*It was God's plan."* When his father up and left him, with no mattress, no

food, no support, no communication, in order to go make money on the border with Guinea. "*Na God* [it is God]." When, after months of all-night studying, Peter didn't pass a single subject in his exam, it was "God's plan." When he was hoodwinked by the testing agency. "Well, I just know, *na God.*" When he got news that his father was in a horrific car accident, couldn't reach him, and then his father didn't express much interest in seeing him. "*Na God."* And when he had shown me the scores of messages written to the various expatriates he had gotten to know over the years, wishing them happy birthdays, Merry Christmas's, Happy Easters, and news of Solomon's death and pleas for help with not a single response. He just could not understand why someone who was his friend and supporter would up and disappear like that, but, must be *God's plan*.

Fragile Contingency, Left to the Almighty God

This expression, *na God*—or its variants— *I lɛf to Gɔd [It's left to God] or I lɛf na Gɔd in a**n*** [It's in God's hands]or *it's God's plan*— is plastered on trucks, *poda podas* and shop stalls; written onto charms stuck on taxis, community group "mottos" and Afropop lyrics. It is also voiced, almost like a reflex, amidst the quotidian micro and macro forms of bad luck, impoverishment, violence and death in Sierra Leone.

Evans-Pritchard famously interpreted witchcraft beliefs among the Azande of East Africa as a set of logics that answer the existentially-paralyzing questions: *"Why me? Why now?"* Since then, it has been something of a maxim of much anthropological theory that African cosmologies assimilate what we might call "bad luck" into something of "a plan," and thus make meaning of an otherwise cruelly indifferent world. In a place like Sierra Leone, with such high mortality

rates from infectious diseases, but also, as in Solomon's death, from the chaos of peri-urban poverty, these asides reference a type of preordination to life and when it will end. Still, the range of emotions that people convey as they say *na God* often seem more complex than merely deference to a divine plan: sometimes detachment, sometimes what appears as indifference, sometimes tragedy, sometimes hysteria, sometimes pragmatism. I often wondered how much of this frequent recourse to *nar God* was born of the particular histories and political-economic contingencies that had produced Kono's current impoverished and precarious conditions. In other words, was this reflexive reference to an order or rational explanation for it all merely a by-product of the fact that lives and life-chances in Kono are fundamnetally experienced as so out of people's control? Did naming that order to life actually affect the experience of precarity for people like Peter— in a place where life was so constantly precarious?

Wedding philosophy and theologically rich engagements with his decades of ethnographic work in Sierra Leone, anthropologist Michael Jackson has written extensively on this question. The sensitivity of his work comes from a deft type of relativism: the openness to the idea that, poverty, phenomenologically, cannot exist without a knowledge of or an experience of an otherwise[9]—that one must be conscious of the suffering to recognize it as such.[10] Jackson's ethnographic works suggests that the human experience is one of but many *existential* conundrums—how does one balance one's individual desires against those of the group? Why is it that people the world over never seem satisfied with the lot they are given? How does one turn the meandering trajectories a life takes into a comprehensible story? These concerns are dealt

[9] Jackson said this to me in conversation in 2012.

[10] David once suggested that as infrastructure has improved, peoples' sense of suffering has increased. For instance, when "light goes on for four days, you drink cold, cold water then it goes off…just boom" it's worse than if it had never gone on in the first place, and you never knew what cold wter tasted like.

with in varying ways the world over, situated within the material milieu that those who hold these concerns come to know.

So I tried to read Solomon's death and his family's reaction attuned to Jackson's phenomenological framing: his death was a rupture in the sense of it being hideous and surprising and intrusive in its location – as one might imagine such a loss in this way would be anywhere—but a four-year-old dying is not in and of itself a rupture in Sierra Leone. The struggles and traumas of Solomon's family were assimilated into a thread in the fabric of what they had come to know and expect out of a life beholden to structural forces beyond their control.

But I was also attuned to the limits of this rendering. For one, Jackson's skepticism at the utility of speaking of poverty, given that the condition of *poverty* requires an experience of an otherwise (which, presumably rural Sierra Leoneans do not have) effaces the fact that, as James Ferguson writes, globalization "has brought an increasingly acute awareness of the semiotic and material goods of the global rich, even as economic pauperization and the loss of faith in the promises of development have made the chances of actually attaining such goods seem more remote than ever" (Ferguson 2006:21). The references to "This is Africa" and "For you people in America things are different," one hears in Kono underscores the fact that lifeworlds and life-chances in postcolonial and globalized Africa are consciously and often explicitly defined in relation to a known otherwise, that is, a global order in which Africa and the *sɔfareshɔn* (as one says in *Krio*) therein ranks last. The quest for wellbeing and meaning does not, in other words, exist on some level playing field, and the hyper-localized phenomenology of poverty offered by Jackson's existential anthropology may gloss over the much more cosmopolitan way in which people in rural Sierra Leone now compare and make sense of their conditions in a world order.

Efforts to secure stable futures and wellbeing in Kono emerge from a stance of understood abjection, of being left-behind in a rapidly modernizing world (Ferguson 2006). And this abjection no doubt colored the type of despair that seeped into and through Peter's stoicism when he said that his brother's death was a result of God's plan.

Furthermore, in Jackson's writing, the quest for *meaning* and *a logic* to the world seems to take precedence over the quest for material stability, the fulfillment of basic needs, or even for survival[11]. Ethnography of course must be attentive to the processes through which those facing war, impoverishment, illness and other forms of violence assimilate those contingencies into a legible world-view, but there are places where such material instability is simply more disorienting than others —existentially, cosmologically, intellectually and in terms of the raw requirements for survival. More might be said, in other words, about how material conditions, political economies and indeed the varying threat of illness and death are refracted through culture and stories.

Sverker Finnström writes in his ethnography of war-torn Uganda that the function of African cosmologies as mediated through shared discourse, stories, ritual and relations, to make "every phenomena…comprehensible and comparable with other phenomena" (Finnström 2008:7). But these cosmologies are not static. My interlocutors in Kono, like Peter, also doubt, reflect, play with, or deploy with irony their own "beliefs" that order a world wracked with contingencies. That uncomfortable middle ground, between a kind of anthropology of structural violence that evacuates the interior life of subjects, and an existential anthropology that presumes a kind of effective meaning-making capacity to culture, religion and belief (and in so doing, in part, absolves the ethnographer of considering the affective and existential terror of

[11] A point also raised by D'Angelo (2019).

contingencies that exceed meaning-making) is where I want to dwell in this chapter. How can one attend both to the "patterning and systematic manner" in which "people who live together articulate and mediate experiences and stories" (7) and to the experience—and suffering— born of uncertainty*?* How does one write with this uncertainty amidst loss, contingency and unstable futures? As Peter said: maybe the man ran over his brother as a sacrifice for a witch, maybe because he's just evil or a witch himself. Maybe it happened because roads are built next to houses and, with no indoor plumbing, poor children in Kono need to brush their teeth at their doorsteps, hunched over. Or maybe it was simply a mistake, no justice to be found, no going back. It just happened because it happened.

The history, ubiquity and routinization of death in Kono at times seems to exceed the capacity of a cosmology to assimilate it. In other words, it becomes uncertain what exactly *na God* signifies. Did Peter really believe that a deity in the sky decided that his brother was to be crushed by a car in his own house? Did this affect the experience of losing his beloved brother—and all the other misfortunes he had experienced to date? Peter's expression and affect belied any notion of certainty as he explained the story to me, his expression: "I don't hope for anything like this for anyone," revealing more provisionality than his religious vocabulary allowed. Did Peter deeply believe that despite every indication otherwise—relatives who have died in poverty, a family decimated during the civil war, no lifeline to cling to—that this suffering would bear fruit in the end?

The charismatic Christian communities in West Africa like that to which Peter belonged have proliferated, in part, because of their rendering of (inescapable) pious poverty as the necessary price to pay for an inevitably prosperous future. The end-times and prosperity narratives that circulate in church services and sermons index a more general malaise with the

present and a desire for what Charles Piot calls "a future that replaces untowards pasts" (Piot 2010a:20). Within these communities, expressions like *na God* circulate to suggest, as D'Angelo writes, "the existence of divine order in which everyone will—sooner or later—receive reward or punishment" (D'Angelo 2019:45). Understood as a representational phrase, *na God* signifies a notion of fatalism, but one oriented towards a future that must be worked towards and that makes the current suffering worthwhile, or at least meaningful and *knowable*. And while the force of religious experience certainly resides beyond a kind of intellectual and interior set of beliefs alone, and rather emerges through ritual, embodiment, materiality and the force of collective religious practice, Peter was adamant that religious experience, and being a good Christian, was a matter of faith and unwavering belief.

Perhaps, Peter's recourse to *Na God* may be more akin to a performative speech utterance, an illocutionary speech act, a kind of ritual discourse: invoking, insisting upon and in the process creating an order to the contingency (Tambiah 1968; Finnegan 1969; Ray 1973) Maybe reference to "God's plan" stood in, so to speak, for an absence of anything else to say, like a ritual that offers a structure for how to assimilate the chaos of tragedy and loss

I think of here of Nigerian writer Chigozie Obioma's (2019) epic *Orchestra of Minorities.* In this novel, a poor Nigerian man's odyssey of misfortunes is narrated from the perspective of his *chi*, his Igbo personal guardian spirit. The spirit can flash thoughts through the man's head, reminding the man that he does have a divine figure watching and advocating for him in the domain of the gods. But the *chi* cannot intervene as the man experiences one terrible misfortune after another—being scammed and tricked, lied to, falsely imprisoned and ultimately losing his beloved through his own doing—and merely watches with frustration. This is a Job-like epic, but there is no redemption at the end.

This is a peculiar relationship engendered between the *chi* and his charge, one that perhaps speaks to a particular experience of enchantment in contemporary West Africa[12]. While Obioma draws on Igbo cosmology in his characterization of the *chi* and the spirit world in which he lives, the limits on the spirit's capacity to intervene in an otherwise arbitrary and indifferent world are Obioma's own inventions. The man has a kind of unwavering faith in the spirit, a kind of existential comfort that he is always in the presence of the *chi*—a relationship that reminds me of Peter's connection to the phantasmal ex-patriates in America he had met and continued to write diaries to each week, or even to the God of the Prosperity Gospel he prayed to in church. But this type of belief is not, necessarily, tethered to any ordinary type of hope.

In this context, the relationship between spoken signifiers of meaning and what is actually signified by them is ambiguous and fragile. Even Evans-Pritchard, in his final chapter of *Witchcraft Among the Azande*, undoes what may earlier have seemed a hermetically-sealed treatment of the explanatory logics of witchcraft beliefs: "any description of [witchcraft beliefs] must appear somewhat haphazard. Indeed, by treating them all together I have given them a unity by abstraction that they do not possess in reality" (Evans-Pritchard 1963:221). Here, I want to consider the "religious vocabulary of contingency" (D'Angelo 2019:45) attuned to, in Evans-Pritchard's words, "the plasticity of beliefs as functions of situations" (221). In particular, I am interested in how the phrase "*na God"*, in certain situations, slides into another *Krio* expression: *"aw fɔ du, pas yu manej"*—"what can you do, but try and manage." A certain notion of fatalism underlies both of these two poles of explanations for contingency, but the former indexes a different temporality of the suffering. "God's plan" then, serves as, in Evans-Pritchard's words, as a *haphazard* mediator of the precarity of the everyday.

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[12] Peter's Pentecostal community would, of course, cast any reference to Igbo Chi spirits as akin to Satanism.

How does one invoke an order to one's life, when, at the same time, that life is again and again experienced as so out of one's control? At times, peoples' stories make sense of life and deaths in Kono; at times, people seem split and alienated from the stories they tell; at times, peoples' language seems to do more than represent a set of concepts or beliefs; at times, as Peter seemed to say, all one can do is face the indifference of the world without trying to make sense of it, or, as Nigerian author Chimamanda Adichie writes: "There are some things that happen for which we can formulate no whys, for which whys simply do not exist and, perhaps, are not necessary" (Adichie 2012:303).

Misfortune as Commons

After I met Peter and his mother at the Church compound in the wake of the accident, I returned to Freetown and had a drink on the beach with David. I was mulling it all over, the opacity of Peter's affect and experience. I explained Evans-Pritchard's theories of witchcraft and contingency to David, the fact that "*Why me*?" is a question that drives so much of human cultural and religious life. David took a sip from his Fanta bottle and responded with an interpretation that disoriented me:

> I'd just think that if something bad were to happen to me, it had to happen to someone, and it could have happened to another person who would have the same feeling as me, so why get so concerned about "why me?" It happened to me because it did, and if not me, someone else would be feeling it.

There was such an immanent inevitability to misfortune in this formulation. David's words seemed to offer an insight into a particular relationship towards the future. The future can only hold misfortune, for you or for someone else. David's portrayal of contingency as a kind of

commons in Kono, the fact that there was a sharedness to misfortune, opened up a set of questions about the possibility for ethical thought and action in this case. Does one aim to absorb the misfortune as an ethics of sociality? What possibilities for exit, escape, voice or even agency remain amidst this existential arbitrariness, other than displacing the misfortune onto someone else or taking it on as a kind of sacrifice oneself?

For the remainder of this chapter, I consider the ways that some of these dilemmas are woven into the fabric of everyday existence in Kono. I am interested in how Kono's position as the center of the country's diamond trade in part engenders this relationship towards the arbitrariness of misfortune or even death. That is, these relationships to contingency and misfortune in everyday life not do not emerge *sui generis* or out of religious or cultural domains alone. Rather, they have a great deal to do with how powerful political-economic histories reaching back to colonial times reinvented the terms of precarity and opportunity along the lines of mining capitalism. On top of these histories of diamond mining is now laminated an unpredictably life-changing or -breaking terrain of humanitarian care. These histories converge at the level of subjectivity, engendering certain relations to contingency: a familiarity with jolts of powerful hope and a sense of proximate improvements that punctuate lives that, broadly, people feel they have very little control over.

In Sierra Leone, Kono is synonymous with the diamond trade. This is evident from the winks the Immigration Officers give you when they see a Kono address listed on your landing card, to the detainments at the police checkpoints on the way to Koidu, the District's dusty city capital, to the Sierra Leonean kids who stop you on the street in Koidu, pulling out a small, folded paper with a diamond inside to sell. Diamonds, gold, bauxite and iron exist elsewhere in Sierra Leone, but Kono has long been thought of as the epicenter of the country's diamond

industry, with the richest deposits, the largest number of people working informally or formally in the mines, and a long history of extraction, displacement and political instability as a result of the trade.

Stories of an earlier time when Koidu was known as the "Paris of Africa" and the land was flush with diamonds conjure a melancholic relationship to the place today. Now, international actors in the mining industry and local authorities swoop in with an unpredictable rhythm and, shrouded in opaque dealings and confusion, reclaim and destroy peoples' agriculturally productive land. These reclamations often lead to initial eruptions of resistance and ambitious outrage, but, as structures of accountability to which affected people might turn soon dissolve, it becomes difficult to imagine what one could even do to stake a claim to a livelihood or a sense of rootedness to the place. All the while, "artisanal" miners continue to shake through gravel that has already been sifted by foreign mining companies in pursuit of a stone with no known use-value, but which is laden with the possibilities of radically transforming the trajectory of one's life.

An ethnographic immersion in the mining economy serves as a window into how social and economic life is imagined, organized and experienced in Kono: the machinations of postcolonial local authority and power that are so opaque that at times there is no other answer but to throw up your hands and say: *"dɛn dɔn kil wi!";* a sense of space and time in which a past was rich with possibility that always, necessarily stands in contrast to an impoverished present—until, that is, that moment when luck, magic, the ground and "*God's sorryness*" coalesce and somehow, in front of you, is the 40 carat stone that will just lift you out of this place leading only to a sense of "shock." The sense miners describe of at once moving along vectors towards salutary and prosperous futures, but at the same time being stuck in a present of uncertainty and

constantly bad luck—the swings back and forth, the affective oscillations—resonates, for instance, with Peter's own way of describing the promise of prosperity gospel amidst the abjection of his brother's shocking death, or the hope of a humanitarian relationship bearing fruit, despite the overwhelming evidence it will not.

The world-making and world-breaking economy of mining, in which attachments to place, to labor and to futurities are so fragile, in other words, might reveal something how a crisis like Solomon's death might be lived-through without complete explanation; how a woman might relate to her daughter's demise from malnutrition with confounding dispassion; how a family might encounter an epidemic response with what appears a kind of stoic resignation towards the arbitrariness of death, even as it sweeps through their compound.

The Congotown Bridge Affair

On July 27, 2016, Koidu City lost its only direct connection to Freetown. I don't recall when I first heard about what was unfolding on the outskirts of Koidu—maybe from clusters of men speaking loudly about the "Congotown Bridge" in town or maybe my assistant David told me we should really check out what is happening, or perhaps one of my former colleagues from the NGO told me I really ought to stay in that night due to the "security concerns." I had seen construction machinery alongside the main bridge out of the city in the preceding couple of weeks, but I hadn't known how to interpret it and frankly the trucks and machines did not stand out much in the swampy, muddy landscape peppered with the carcasses of other construction equipment.

These bulldozers were identifiable to those who knew what to look for: they had the name "Pluto" painted on their sides, alongside a crude logo representing the planet. These were Max's machines and they had materialized one day—nobody had expected it—and begun demolishing the highway bridge. When this story reached me, I of course asked, "Who's Max?" David chuckled, passively waved his left hand: "That one—that one is one of the real famous…let us say *tycoons* in Kono. Ha! You know what they say about him: that he's so arrogant he even blows his *djamba* [marijuana] smoke in the *President's face!*" Puffing out his own lungful of *djamba*, David told me that Max was a crazy Israeli[13] who had washed up sometime a while back in Kono. He was also reputed to be the founder and head of Mercury International Sports Betting, a national sports-gambling system. A large proportion of the unemployed young men who hang out in Koidu's *ataya* bases are occupied throughout the day arguing over the crumpled receipts they are given by the Mercury registers that line the market stalls after placing their bets.

Max's equipment had shown up at the Congotown bridge, everyone knew, to look for the diamonds underneath. The area was well known to be diamondiferous (the swamp sits in the shadow of the massive Koidu Holding's industrial mine tailing pile) but just by virtue of its central location as the only road out of town the area had been largely preserved over the years. As I worked to piece together what exactly had happened that week, I spoke with one local politician who told me that during the war, "Even the rebels executed anyone who tried to mine there." The regulation on mining in this area was also codified into post-civil war Sierra Leonean law. The 2009 Mines and Minerals Act articulates specific protocols for mining land within a 200-meter radius of a city and "set apart as a public highway," and such areas can only be mined

[13] In fact, he is reported to be a Jewish man from Belgium.

with the "written consent of the local authority having control over the township" (Republic of Sierra Leone 2010:25). But Max's equipment appeared nonetheless and started digging into the foundation of the bridge. At first, cars could still cross the site, but as the workers continued to dig, the swamp slowly expanded, flooding peoples' gardens, verandas and concrete houses.

David told me that everyone knew that area was not supposed to be mined, especially given that it was a critical route out of the city. But with no rebels around to threaten executions, and Max's equipment continuing to demolish the bridge, it was not clear which institution was supposed to intervene. The local authorities tasked with regulating mining expressed futile pleas through the media. An official from the Sierra Leone Government's National Minerals Agency was quoted in a local newspaper as saying "[It] is illegal and my office has condemned it regardless of who was involved in it" (Septimus Senessie 2016). The regional head of the Environmental Protection Agency likewise told Reuters: "We've contacted people in our own agencies, we've sent notices for them to stop, but the mining goes on" (Inveen 2017). All bureaucracies are, of course, made up of people; systems of accountability, adherence to written law, faith in a kind of politically-sanctioned and commitment to regulative norms are just that—a kind of faith. But in moments of political chaos in Kono like that surrounding the Congotown Bridge destruction, one becomes viscerally aware of how the political institutions that have been built to, nominally, constitute a system of accountability can just dissolve into a set of spokesmen with ID cards. Individual regulators watch the mining from their motorbike and empty offices and make pleas in the local newspaper. But the mining continues, indifferent to legal stipulations and the livelihoods of affected people, as it quite literally undermines the ground on which they live.

There is what Africanist scholars call a "shadow state" in these moments when the regulatory state seems to evaporate: the "substance" of patrimonial politics, the nodes and arrangements of political power, the cabals between Chiefs, Big Men, tycoons and miners that have their own forms of regulation, hidden behind what Paul Richards deems the "carefully constructed film-set-like structure approximating Western theoretical notions of the 'modern state'" (Richards 1996:35). But since the country's civil war ended, a conflict that had in many ways been fueled and financed by shadowy trades in diamonds, a great deal of activity by international development institutions and governance NGOs have sought to formalize scrutiny over the diamond trade. The Kimberly Process, implemented in Sierra Leone, certifies that diamonds entering the international market are conflict-free and properly sourced. National Mineral Agency offices have sprung up in the major cities and towns and European donors have supported a network of civil society organizations to monitor and advocate for the rights of mining-affected communities in Sierra Leone. Behind the scenes, European technical advisors and consultants have worked to digitalize mining agreements and make more transparent mining companies' financial arrangements.

But many miners tell me it is easy to skirt regulations by bundling diamonds into one licensed mine. And for the farmers in Kono whose land is suddenly flooded, the lorry drivers who cannot leave Freetown because the bridge has been demolished, the market women who realize they have just been cut off from supplies of goods, these initiatives too appear illusory in the face of aggressive actors in the industry like Max. I am often left with the image that when someone like Max wants to mine, that "constructed film-set-like-structure" of a state—one that reflects the technocratic, donor imaginary of a neoliberal state facilitating, monitoring and taxing its extractive industries—melts into a kind of sand, and slips through one's fingers.

At first, *poda podas*, vehicles sand trucks could skirt the mined roadway on the Congotown Bridge by a muddy embankment. But soon the tire ruts deepened, and the improvised detour expanded through a nearby village. As the village roads also sunk into themselves, brown water overtook the detours and minivans got stuck. Kono was cut off entirely from Freetown, and with it all the imported food and supplies for the District. And Max's companies continued to cart away the gravel to be processed and sifted away from the construction site.

As the local residents became more vocal about their discontent—eventually, over 60 people lost their homes in the flood (Inveen 2017)—and after Max's own company had removed several weeks' worth of gravel, the now-dystopic appearing landscape was, rumor had it, opened up to "the people." This triggered a rush of youth with buckets, shovels and shakers from Kono and nearby regions and diamond-buying *djula* (Mandinka traders, often from Gambia) to hang back, observing at the scene, waiting for the miners to bring a stone to sell.

Soon after the site was opened up, I went with David to observe the scene. The day was gray, the middle of the rainy season, and the entire area was so swampy and wet it was hard to tell where the mining began and ended. The river that the bridge had crossed continued in either direction, marked with tall swampy grass and reeds, but what had been a paved crossing had collapsed into a giant muddy heap. I peered into the pit, and saw dozens of men in dirty rags, almost manically digging up dirt, tossing each shovelful into a plastic bucket, and throwing each bucket down a line of people until it was dumped into a pile where it would then to be sifted, washed and shaken through sieves.

The men in the pit yelled at each other, and camouflaged police with machine guns stood around the rim of the crater. David and I walked across the remnants of the bridge. He oscillated

between: “Yes, it’s your right to take a picture, snap if you’d like!” and looking over his shoulder anxiously, checking if we were being followed. We tried to blend into the crowds hanging back, (impossible for me), and listened to what the clusters of men were saying. Several elderly men said that most of the young men in the pits seemed to be from the center of the country, where the President of Sierra Leone was from. They said that word had spread that a “council” had been appointed by the President with heavy representation by an alliance of Temne leaders from the central regions of the country. This council was enforcing a scheme for accessing and distributing the gravel amongst the workers, committee-members and financiers.[14]

These men hanging back from the Congotown site—they were all Kono—complained about the continued marginalization of their people, the disregard for surrounding property-holders whose homes and fields had been flooded and, most of all, the absurdity that the local Paramount Chief had opened up this site to exploitation, first by an Israeli and then by non-indigenes. They felt certain Max had paid the Chief or offered him a position in his business plan. One tall man in a white skull-cap looked at me: “I swear to God, something is going to happen.”

Rumors and Dissolution

[14] This story was particularly incensing: many Kono people hold the Temne responsible for instigating the civil war, as well as taking over the Kono diamond minds to pillage the region’s resources in its aftermath, even while benefiting from the (Temne) President’s ongoing direction of development projects to the Temne regions of the country. These rumors recalled those that had provoked the infamous *Konomokwe* in December 2001, when Kono returnees massacred Temnes ostensibly to reclaim their land after the war had ended. “Many were thrown into wells,” David always said. “That one was very, very necessary.”

The scale of "corruption" and political conspiracy in Kono's diamond mining economy is stunning. But I cannot be sure which of these rumors about the Congotown Bridge mining were true. Was the President himself involved? Why had all the regulatory agencies just disappeared right before the bridge demolition began? Was there actually a cabal of Temne-speakers from the center of the country who had recruited young men to travel to Kono to take advantage of this opportunity to sift through the Congotown gravel?

One might argue that the *truth* of the matter is not as important as the stories that circulate—that these rumors were how news in a place like Kono is consumed and reiterated, that they *were* peoples' truth. But this kind of all-saturating paranoid discourse does more than just represent a set of "beliefs" or "truths." These rumors build on each other and snowball. Their substance may matter less than what they convey; that is, something of the experience of a dissolution of one's life and world and, simultaneously, the recognition of one's impotency in the face of an indifferent politics. In other words, rumors may reflect lived truths or potent critiques of the machinations of power at play in producing such dislocation.[15] And as these rumors emerge and enmesh people who have woken up to the violence of a forced dislocation, they color how one is to think about politics vis-à-vis one's own future. They engender a general sense of futility despite the undertones of anger. When you watch your field be swallowed by muddy swamps and all around you are rumors of the President endorsing it, the scale of the dislocation may seem that much more insurmountable.

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[15] In his book on the Acholi people in Uganda in periods of great violence, Finnström argues that rumors serve as a medium for people to "invoke meanings they found relevant…to comprehend and live the wider, unbounded world that they are caught up in" (168). relevant…to comprehend and live the wider, unbounded world that they are caught up in" (168). From the ambiguous origins of HIV and Ebola outbreaks in the region to stories of European-donated poisoned rice, Finnström not only views these rumors as an empirical entrypoint into the lived experience of such structural violence, precarity and shadowy-machinations of power and violence, but also as a discursive mode in which the Acholi exercise their agency in ordering their world. But one could also engage rumors as reflecting moments of incredible anxiety or the incomprehensibility of the world—of the inadequacy of discursive practices or cultural "resources" to make sense of what is going on.

One week later, as the detour became completely submerged in water, tensions reached a boiling point. Groups of angry youth from other parts of the city had gathered at the mining site, hoping to find the Paramount Chief and Max himself. Both had fled to Freetown, anticipating this tension. Later that evening, the Paramount Chief's compound was stoned. Fearing that the riots could turn dangerous, the local army contingent deployed into the city to enforce a 7PM curfew. When a group of Kono women threatened to stage a demonstration at the site of the mine, the Sierra Leone Minister of State, himself from Kono who had been sent to mediate the growing tensions further outraged the surrounding community by "daring" the Kono to mount a significant protest at the site.

It took several weeks for tensions to simmer, but eventually, the road was reconstructed and re-paved. When the people who had lost their houses requested compensation from the Mayor's office, an even more convoluted story came out—this time from the very authorities who were rumored to be involved in the secret "council." The acting Mayor of Koidu City was quoted as saying that small-scale, illegal miners had subtly but persistently been chipping away at the bridge's foundation for years, to the point that its structural integrity of the bridge had been in question. The local government did not have the funds to access construction equipment, so they reached out to Max and his company to ask for "an act of corporate social responsibility." A Reuters article covered the sequence of events: "We talked among ourselves, and the only name that came up was Pluto. They say charity begins at home, and this is a company that's very involved in our communities," the Resident Minister for the Eastern Region was quoted as saying. "Besides, we cannot license mining the road, but the place where they clean[ed] the unsuitable material [from under the bridge, ostensibly containing diamonds] is licensed. So if mining happened here, it did not happen on the road" (Inveen 2017).

French political scientist Jean-François Bayart (2000) argues that African political leaders have long derived their wealth and capacity to govern from managing (unequal) relationships with external forces and the resources they bring to bear on politics. These are what he terms strategies of "extraversion." In this case, the Minister (and Mayor) garnering financial and political clout by providing a foreign actor access to diamonds is certainly an example of extractive extraversion. But *internally*, to his constituents, this extraversion was legitimated through the language of contemporary corporate social responsibility, philanthropy, humanitarian reason. The local government sought to perform its contract with citizens to keep the roads safe, the minister implied, but was simply too impoverished. The structural reasons for this impoverishment (such as the loophole in mining regulations exploited by Max to cart the gravel away from the bridge) were reconfigured as an opportunity for Max's compassionate and charitable intervention. To people in Kono trying to make sense of what happened or who could possibly be held to account, this is a dizzying and mystifying kind of complicity, in which charity and extraction, philanthropy and dislocation, care and disregard become impossible to disentangle and all come off as disingenuous —all the more so given that, I later learned, an almost identical set of events happened when Max destroyed a different central roadway in the region in 2013.

Eventually, Max retreated into his shadowy role as the betting boss who blows *djamba* into the President's face, appearing from time to time at the one hotel frequented by the mining types in Kono, blasting around the region in his luxury SUV. The local politicians handled the blowback from the Congotown Bridge affair. In the end, residents who lost their homes were only given a plastic water jug as mollifying compensation. One resident spoke to an American

journalist: “So many government people came down here promising us this and that after the flood, but look where we are…They already forgot about us” (in Inveen 2017).

Political and infrastructural entanglements with capital and mining concretely let people down in Kono. But the sense of dissolution that results from an event like the Congotown Bridge extends beyond merely the destruction of a bridge and land. It is not only that people lost their homes or were given merely a water jug as compensation, but, in the words of the resident: they were already *forgotten.* And that capricious misfortune and institutional indifference for the poor Kono farmers were tethered to the promises of subterranean wealth for Max, the council, and the Temne youth who flocked to the scene. People in the area now speak the Congotown bridge affair with a kind of exhausted frustration, and center both their anger and the futility of that anger. As with Solomon’s death, there was no hope here for justice or restitution, no going back; nothing to do but try and manage on.

Koidu Holdings

While mid-level players like Max appear now and then to demolish a bridge or host a beauty pageant or patronize a local politician before retreating yet again to quiet deals in Koidu’s nightclubs and hotels, the Koidu Holdings mechanized mine towers over the entire district. The light from its 24-hour operations and the sounds of clanking of conveyor belts reach villages miles away from the mining concession. The mountain of grey gravel surrounded by an electrified fence grows larger every year, along with the cluster of clean white compounds visible in the distance. A farmer I was speaking to in a nearby village once pointed to the houses, telling me and his children who were also listening: “It is a city of white people in there! With

bars, restaurants, swimming pools and an airport!"

Koidu Limited, the operator of the mine, has a convoluted history in the region. The original operator of the mine given the rights in 1995, Branch Energy, was closely linked to the South African mercenary company Executive Outcomes that had been contracted by the Sierra Leonean Government at about that time to fight back rebel forces who were quickly overtaking the country. Though the company has denied that the rights to the kimberlite vein (a type of rock that has particularly rich diamond deposits inside) were given as a "payment" for Executive Outcomes' services, this is certainly the explanation that people in the surrounding communities use to make sense of how the violence of the war so seamlessly transitioned into the violence of the region's extractive economy.

This causal explanation is buttressed by the fragments of personal war stories that circulate today. "I was a rebel, fighting in the bush. We fought against the South African soldiers," a young man and former Koidu Holdings employee named Bigger told me. I was not used to hearing people be so forthright about their time fighting with the rebels, but he continued: "When they disarmed us, they said: "Oh these guys are the rebels. Oh these guys are South Africans. ...we came together." A local politician who remained in Koidu for most of the war told me that he had watched as the first units of Executive Outcome mercenaries arrived on their infamous gunship in Kono to flush out rebel forces. He said that the mercenaries quickly realized just how much wealth was buried underneath the concession as they saw the remnants of heavy mining activities that had gone on before the war and observed the crowds of local miners washing gravel in the surrounding areas. The politician, who had fought to protect his own home with a small Kono community militia, said the mercenaries moved to guard preferentially the region that would later become the Koidu Holdings mine, despite the continued presence of rebels

elsewhere in district. Everyone in Koidu now seems to know the names of the South Africans who fought with Executive Outcomes, veterans of the Angolan Civil War, who transitioned from mercenaries to the mine's overseers: Gino Coutineau, Jan Joubert, and Dakhulu. "That," Bigger said of the latter, who is thought to be the head of security, "is a very aggressive man."

In 2002, months after the war formally ended, the Sierra Leonean Government entered into a new agreement with an entity called Koidu Holdings. This company had ties to the Israeli diamond magnet Benny Steinmetz (recently sentenced to prison for corruption schemes to gain access to an iron mine in neighboring Guinea) (The Associated Press 2021). Key Executive Outcomes operatives and former-combatants continue to fill top management roles today (Manson 2013), and the mining agreement was reviewed and updated once again in 2010. That lease agreement articulated a fairly substantial profit-sharing agreement with the Sierra Leonean government.[16] The company's website states that the mine's objective is to demonstrate that "through responsible development of diamond projects, the good that flows into the local communities, the economy and the country can outweigh the perceived drawbacks," (Koidu Limited n.d.) presumably by formalizing and institutionalizing a trade that, as one international politician remarked, is "myriad and byzantine; only those intimately involved in the industry truly comprehend its vagaries" (Ian Smillie, Lansana Gberie, Ralph Hazleton n.d.).

But a recent investigative report, prompted by Koidu Holding's prominent presence in the so-called "Panama Papers," suggests that Koidu Limited's dealings and corporate structure may also be shrouded "byzantine vagaries." The report showed that while Koidu Limited's production often accounts for 60-90% of the country's annual diamond exports, recent tax

[16] This includes a gradually-increasing annual lease rent, income taxes of 35% and an additional 8% royalty rate for exceptionally large or valuable stones that are found. An additional 3% was to go to the Kono District Council, 2% to the Koidu City Council and 5% to the affected Tankoro Chiefdom (The Republic of Sierra Leone 2010).

registers report that the company has paid no income taxes at all—a clear example of a structural cause of Kono District's impoverishment.[17] The company has claimed that it is encountering serious financial woes due to falling diamond prices (and the country's Ebola outbreak), and has thus defaulted both on payments to the Sierra Leone government as well as its main investor, Tiffany and Co (The United States Securities and Exchange Commission 2016). Amidst ongoing negotiations between the mine's main creditor, the Sierra Leonean government and Koidu Limited officials, a top company official was covertly recorded saying that the mine's management intended to continue "'run it, stop it and run away" without paying back taxes or investors (Africa Confidential 2015). But the Panama Papers suggested that the company is only a few degrees of separation from a series of shell companies, flush with cash, that may be being used to conceal revenue in order to defer taxes and other payments. The journalists noted that "sources close to the company said that its strategy was to exploit alluvial diamonds, feign financial struggles and leave creditors high and dry" (Gbandia and Sharife 2016).

The Mine

I was allowed into the mine once in 2013, a year before the Ebola outbreak. At the time, a widening crack in the walls of the Ichende Clinic had spread from floor to ceiling. Others in the neighborhood were complaining of similar unsettling cracks in their houses, caused, they were

[17] While Koidu Holdings may have had a particularly nefarious plan to conceal revenue and avoid taxes, post-structural adjustment Sierra Leone is also known for liberally distributing tax exemptions to foreign mining companies in order to encourage international investment in the country. In 2012, the country was estimated to have lost 223 million dollars in taxes due to formal tax-waiver agreements—nearly one-third of what some public health experts have calculated would be the cost of a fully functional health system for the country. And while the country was receiving US$424 million per annum in official development aid over 10 years of Koidu Holdings activity (World Bank n.d.), it was losing US$558 million per year (55% of total trade) to illicit financial flows, in large stemming from the mining sector (Madden 2020; Awoko Newspaper 2017; Budget Advocacy Network 2014).

saying, by the double, rapid fire, penetrating thuds of the Koidu Holdings dynamite blasts that seemed to happen every few days at random times. These thuds would prompt ironic asides muttered under peoples' breath about the increasing collective precarity of the entire situation, a point of connection among strangers passing by: An old man sighing "*ehhhh God,"* as he weeds his garden; a teenager in her school uniform reflexively letting out an "*Ehhhh bo!"* making her friends giggle; a woman, walking with a basket on her head and a child holding her hand, yelping a bit followed by: *"Oh-oh, dɛm wan day wi*! [Oh-oh, they want to die us!]" Among the clinic staff, jokes about Koidu Holding owing us a new wall turned into a more concerted effort to see if they might give us some money as part of a Corporate Social Responsibility scheme, or at least some construction materials for the clinic's expansion into a hospital. I felt uneasy at the prospect of taking their funds, but resources were tight and there were never enough drugs in the clinic—if this could help, we thought we should consider it. A colleague had a contact high up in the company and he arranged a meeting.

A motorbike taxi dropped me off, dressed to my best, at the security post near a gated entrance into the massive mound. There, a disconcerting assortment of soldiers in camouflage, heavily armed police officers and private security guards checked my credentials and radioed for a vehicle to usher me in. I climbed into a frigid Land Cruiser and was slowly driven over the leveled roads, lined on both sides by trees, near buildings that may have contained the supermarket, canteen, swimming pool or hospital, until I was let off at a modular white building. Inside, I met a stocky, middle-aged South African man in safari shorts and boots. He listened as I spoke about our aspirations to build a "state of the art facility." The man nodded, and said: "We can take a look. But listen, we're not in the business of…community development. We're a company. And everyone looks at this place and thinks we must be pulling out millions ever year,

but we're not—we're still digging ourselves out." I had heard that this was a recurring refrain from Koidu Holdings, justifying the very limited philanthropic development projects (even by Sierra Leone extractive industry standards) they had sponsored. But I had also seen airplanes flying in and out of the mine— and *everyone* knew that the company delivered an "envelope" each month to the President.

Later that week, the man came to visit the clinic with a Sierra Leonean employee from the mine. He looked unimpressed as the Ichende International doctor showed him the various rooms and a throng of excited staff followed awkwardly close behind. The South African man was distracted. He said he was waiting for a call from "Chief" authorizing the next round of blasting for the day. After the tour, he said: "Well…. we'll have to think about it," shook my hand, and left.

We never heard from them again. A couple months later, as Koidu Holding's (at least publicly stated) financial woes continued to mount, I received an email message and then call by a well-known Hollywood actor who said he had had a transcendental experience during a recent visit to Sierra Leone to learn about the poverty surrounding the extractive industries. We would miss each other in Kono, but he said was planning to purchase Koidu Holdings and run it as an ethical social venture project to funnel the proceeds towards the clinic. The actor rang my phone and said, "Hey, listen, sorry we're missing each other, but we're really going to do something great here—let's do something really great together." This was not the first of the many "ethical mining" ventures (as the directors called them) that had been launched in Kono. I had been in touch with a set of young American social entrepreneurs who claimed to ethically source diamonds for their own jewelry in Kono. Then they purchased a license for small plot of land where they blew their funds without much success; then they brought in a young American heir

to their venture who said he trying to set up a program for the ultra-wealthy ("*Sheiks,"* he kept saying) to fly in on private jets to Kono and then to mine for their *own* diamonds. At every stage of these "ethical" mining ventures, we had been promised some of the proceeds as their "social impact" partner, but they never amounted to anything.

So, I was skeptically optimistic. Yet, in the end, we never did hear from the actor again. The crack in the clinic's wall continued to widen with every blast, not unlike the frustration with unfulfilled promises that follow these jolts of hope. All the while, Koidu Holdings continued to churn out kimberlite and extract diamonds.

Resettlement

There is a certain irony to the Koidu Holdings employee saying that "we are not in the business of community development," given that the mine, over the past ten years, has played such an enormous role in shaping the community's development, broadly defined: from Kono's spatial configurations, to the forms of available employment in the region, to eruptions of political activity and violence, to an entire swath of land that has been transformed from a productive agrarian region to abject peri-urban poverty. In order to carry out all this "development," I learned, Koidu Holdings had relied on the Paramount Chief just as the British colonial State had beforehand.

In 1922, British explorer and then-Governor of Northern Nigeria Lord Frederick John Lugard articulated the British strategy of Indirect Rule over its African protectorates. The British would identify and institutionalize an indigenous elite, empower them to be the "direct" enforcers of day-to-day laws, taxation and land distribution, and cultivate and maintain

relationships between colonial authorities and these local rulers in order to maintain authority in the region and fast-track economic development. “The essential feature of the system…is that the native chiefs are constituted ‘as an integral part of the machinery of the administration,” he wrote. “There are not two sets of rulers—British and native—working either separately or in co-operation, but a single Government in which the native chiefs have well-defined duties and an acknowledged status equally with British officials” (203). Indirect Rule sought to build stable systems of governance upon existing political structures while requiring minimal financial investment on the part of the British government. As political scientist William Reno points out, this outsourcing of responsibilities to indigenous leaders was also an admission of the “incomplete domination of the colonial state” (Reno 1995:28), at least in Sierra Leone which at the time was widely viewed as a financial sink-hole for the Crown.

In 1896, the British expanded presence beyond Freetown and established indirect colonial rule in the rural peripheries outside of the city (called the ‘Sierra Leone Protectorate’). Unlike other British protectorates such as those in parts of today’s Ghana and Uganda, Sierra Leone had no stable, pre-colonial state or centralized system of governance at that time on which to scaffold a new system of Indirect Rule. Anthropologist Paul Richards (2005) notes that throughout the 19th century, the area that would become the Sierra Leone Protectorate had been ruled by warrior-chiefs who had amassed wealth and power by deploying large armies of warrior-slaves as mercenaries for coastal mercantile chiefs engaged in the Transatlantic Slave Trade. Though elite rule and brutality in West Africa certainly existed independently of European traders arriving in search of slaves, the entire cultural and political order of the region in the 18th and 19th century was characterized by inter-clan violence and predation provoked by and deeply entangled with the trans-Atlantic slave trade (Shaw 2002b). From 1896 on, when the British

government formally established the Protectorate, these warlords were dubbed 'Paramount Chiefs' and, as Richards writes, 'this froze in place the practices and privileges of the nineteenth-century forest warrior chiefs' (582). When one colonial Governor named Frederic Cardew took a tour of Kono soon after the establishment of the Protectorate, many of the elders in the region refused to come meet him. "Therefore, he unilaterally recognized the ruler of Kainkordu, Gbenda, who came to see him, 'as chieftain of this portion of the Konoh country'," writes Arthur Abraham, a historian of Sierra Leone. "Thus, in the new colonial scheme of things, Cardew had *created* a Paramount Chief who was recognized as superior to the other rulers who failed to see his Excellency" (Abraham 1978:239).

The Protectorate was divided into a series of chiefdoms each governed by a Paramount Chief, and these rulers were given the authority to create and enforce local laws, operate local judicial systems, levy and enforce taxes, call for and mandate "communal labor" and distribute and charge rent for the land in their chiefdoms. To this day, as the "custodians of the land" in Sierra Leone, they are the formal owners of nearly all land and thus have the sole control (with an elaborate system of sub-chiefs beneath them) for the distribution, management and even reclamation of utilized surface land. Richards goes so far as to claim that this system, in which the vast majority of Sierra Leoneans are formally land-less and liable for mandated collective labor at the Paramount Chief's bidding, is akin to an institutionally-sanctioned form of slavery (Richards 2005).

Through the colonial and post-colonial period alike the "vast majority of rural Sierra Leoneans continue to rely upon chiefs to authorize and guarantee the 'native' identities that confer rights to land, legal protection, and political representation" (Fanthorpe 2001:383). While some former colonies reformed their systems of Indirect Rule through independence), for

multiple reasons—though largely due to tensions between Krio inhabitants of Freetown and rural indigenes—Sierra Leone maintained the selection, roles, authorities of Paramount Chiefs in nearly an untouched form. In each Chiefdom in Kono, there are several "ruling houses" which are families that were identified by the British as eligible to run for the chieftaincy. Paramount Chiefs are elected for life by members of a "chieftaincy council," which contains one member for every 20 taxpayers in the chieftaincy. But this quasi-democratic system of "chieftaincy councils" masks some inventive dealings. Chieftaincy races often come down to which candidate can spend the most money on local tax booklets as possible. Each tax "booklet," containing about forty receipts that are supposed to be filled out when a citizen pays annual tax, boosts the reported number of "taxpayers" in the Chiefdom and thus the size of the Chieftaincy electorate. Candidates purchase the receipts for individuals, which allows them to amass a following of loyal "elders" who will vote for them.

Indirect Rule was reaffirmed in the 2009 Chieftaincy Act. According to that law, "a recognized ruling house is one that has been established and in existence as such at independence on 27th April, 1961"(Republic of Sierra Leone 2009a:6). Paramount Chiefs are still elected for life and can only be removed after a public inquiry directed by Judge of the High Court and the President "is of the opinion that it is in the public interest that the Paramount Chief should be removed" (Republic of Sierra Leone 2009b:10).[18] The staff of the National Archives in Freetown told me that their work today is almost exclusively studying colonial documents for reference to families being deemed eligible to run for Chieftaincy; their cell phones seemed to ring every hour with other families hiring them to do this research. David's brother, an academic in

[18] While there is more flexibility in who eligible to run for chieftaincy than colonial customary law might have one think (FERME 2003; Ferme 2018a), and in some ways the situation in Kono is unique given the Chiefs' central roles in brokering access to diamond mines (Reno 1995), the colonial origins of this "customary" political system continue to have great influence over the machinations of rural politics.

Delaware, sought to run for the Chieftaincy himself in the mid 2000s. But his candidacy was only accepted by the Sierra Leonean Government Provincial Secretary (the mediator between the "customary" rural political system and the central state, an administrative role that was preserved through decolonization,) David told me, after the family found a line in the colonial archives in the city of Kenema, in which a British officer had simply noted that an ancestor was a "wealthy and important man."

Indirect Rule Redux

Koidu Holdings' official position echoes that which the South African employee told me in his office: the company is not a "proxy government" responsible for building roads, schools, clinics and other essential social services (Maconachie 2016). Nevertheless, the company has publicly claimed—both to international audiences and within Sierra Leonean media, political events and billboards lining the highway into Koidu—that its activities are a harbinger for wide-reaching community development for impoverished communities in Kono. The primary mediator for the company's activities on the ground—both philanthropic and extractive—is the mining concession's Paramount Chief.

Chief Sumana grew up in Kono with a reputation for being a wild youth, but fled to the United States during the war and worked as a truck driver for two decades there (Polgreen 2007). He returned soon after the war and contested the Chieftaincy Seat and was elected as it became clear that Koidu Holdings (operating within his Chiefdom) would become the behemoth player in the country's diamond economy. Though the specific nature of Koidu Holdings' financial and personal dealings with the Paramount Chief are still shrouded in mystery and rumor, the

intimacy of their relationship is no secret at all. The Chief is frequently seen traveling with high-level officials from the mine, South African employees refer to him as a confidante, and the mine's website contains a full colored cartoon featuring the ruler explaining the nature and good intentions of the mine's expansion plan to his subjects and "the youth." The Koidu Holdings lease agreement was originally signed by officials of the Sierra Leone national government, long before the current Paramount Chief was elected. Some in Kono maintain that Chief Sumana's hands are tied. But there is no doubt that Chief Sumana has come across fantastic amounts of wealth as he has been elevated as the primary mediator between the mining corporation and the surrounding communities. The Chief's own compound has grown significantly over three years, with multiple satellite dishes and the tops of several SUVs visible over the shards of glass that stud the top of the compound's walls.

Over the last decade, significant tensions have emerged between the mine's administration, affected community-members and the Chief who serves as an intermediary between the two. There have been at least three periods of violence in which protesters have been shot and killed by police and nearby government buildings have been burned to the ground. These conflicts emerge largely because of the company's disregard for local villages as it implements a massive expansion plan throughout the region. In rural areas such as Kono, Since Paramount Chiefs are officially owners of nearly all surface land, they are formally able to largely unilaterally distribute leases to those who seek to farm or mine it. So, village by village, representatives from the company and representing Chief Sumana have shown up to meeting huts and individual households to order people to pack up their belongings, abandon their farms and move to Resettlement (Wilson 2013:260). Thousands of houses have been destroyed and families

resettled on a large muddy flat on the outskirts of Koidu City known colloquially as "Resettlement."

James, a former director of a major mining advocacy organization in the country, told me that since the company's entrance into Kono, he and others were resigned to the fact that Koidu Holdings' "first priority is to make a profit." But his organization (something of a "donor-darling" civil society group that has been supported by a network of international donors) told me that he had thought grassroots organizing and education would create some semblance of accountability as the mine expanded into inhabited villages. "In the beginning we were [optimistic]... We thought those were the early times, the company is just starting operations... if we [can] kind of have this engagement with them constantly, we can remind them" of their responsibilities in the lease agreement. "The first thing we did was to get [affected property owners] to organize themselves into a group that can represent them on their own. We thought we should give them the knowledge about what the laws are, the Koidu Holdings agreement itself which was not easily available, the Mines and Minerals Act and all of those policies surrounding the mineral sector."

I was surprised that James had had so much faith in the legal system to enforce corporate accountability, given experiences like the Congotown Bridge Affair, when the regulatory bureaucracy seemed to just dissolve in the face of a financial opportunity. I wondered if his organizing constituted something of a corollary to the "shadow state"— a "carefully constructed film-set-like structure" (Richards 1996) approximating the liberal donor imaginary of civil society advocacy groups like his own (a "shadow civil society," perhaps). But James insisted that they had some real success in the early days. Their initial work centered around improving the building materials used in the resettlement houses. Then, conflicts arose about the company's

refusal to pay people who were being resettled for their farmland and crops that were lost in the process. Eventually, an Affected Property Owners Association was successful in requiring that all re-possessed land be visited by an assessor. But the lump-sum payments that had been provided since then often frustrated villagers given that decades-old cacao and coffee groves, which would have borne fruit for years to come, were simply bought-out with a flat-rate, and farmers were often not given much fertile land to utilize after being resettled into a new concrete row-house. Since the resettlement process began, thousands of villagers have been pulled from their productive, agrarian family villages, depriving them of a living once the crop payments run out.[19] And while in 2001 Sierra Leone, with great fanfare and donor support, launched a Diamond Area Community Development Fund program that was to disburse tax revenue into development projects in heavily-mined communities, this Fund is also largely controlled by the Paramount Chief and his allies (Jackson 2007; Sierra Leone at the Crossroads: Seizing the Chance to Benefit from Mining 2009; Maconachie 2012).

Over the many days I have spent speaking with people living in Resettlement, I have never heard people talk about the colonial history recounted above—nor the historically arbitrary nature of who is now considered eligible to run to be a Chief. Political officials and local people alike, including those now living in resettlement homes, refer to Paramount Chiefs as "Traditional Rulers" and "Custodians of the Land," even if they say that the particular Paramount Chief in question is an evil man. Rumors circulate about the elaborate rituals and

[19] There is an ongoing lawsuit that has been heavily covered in international media in which a group of 73 affected community members is suing Koidu Holdings for potential millions of dollars for the health effects of living near the mine, including respiratory infections and headaches (abject poverty is not included as a 'health effect' of living in Resettlement). International law firms are assisting these plaintiffs in the court case which has been working its way through the Sierra Leonean legal system and nearly led to a freezing of Koidu Holdings' assets. But not a single person I spoke with on the outskirts of the mine had heard of this lawsuit nor knew who stood to benefit nor who was claiming to be a plaintiff.

secret society initiations that are required, depending on the Chief's linguistic group, to prove a candidate's worthiness and esoteric knowledge of the role's traditions. The Chiefs themselves are publicly coy about these initiations, reliant on the kind of occult authority that surrounds the role. Some of these rites resonate with Chieftaincy rituals described in early ethnographic literature, but it is difficult to tease apart what, exactly, what is rumor, what is actual age-old practice, and what was invented by the British.

For instance, the Kono word for Paramount Chief translates to "Paper Chief," which is likely a reference to the colonial bureaucratic process that validated a Chief's authority with a certificate. But when I asked David why the highest customary ruler would be called "Paper Chief," he said that he thought that the British had merely substituted the "traditional" Chieftaincy staff for a paper "certificate" at some point in colonial history. In fact, while there are references to staffs being "symbol[s] of authority" before British colonization, the Staff became the critical object designated and controlled by the colonial Provincial Secretary in its administration of Chieftaincy elections and governance. Furthermore, in 2011, the UK Department for International Development, seeking to re-invigorate the Paramount Chieftaincy as a key institution for the decentralized post-war development agenda, purchased new, cheaply-made staffs to hand out to all Paramount Chiefs. These were distributed at a national assembly commemorating the country's independence and the 50th anniversary of Queen Elizabeth's visit to Sierra Leone (Ferme 2018b:153). The Chieftaincy is, in other words, a nexus of symbols and claims to legitimacy that have been palimpsistically written and rewritten from the precolonial period through this current epoch of humanitarian international development, all masking and convoluting traditional authority, colonial rule, economies of extraction and Western (colonial

and humanitarian) imaginaries of African traditional culture.[20]

In summary: the Paramount Chieftaincy has been mystified with the trappings of culture and the erasure of colonial history. When the Chief of a diamondiferous area today, who by all accounts is a "traditional" ruler and custodian of his subjects' land, seems to stake his authority purely through rent-seeking, patrimonialism and a convoluted though deeply influential relationship with the central government and foreign extractive corporations, how is one to make sense of one's own indigenous authority system and relationship to culture, space and kin? Often, when I have probed those in now living in Resettlement what they make of the Paramount Chief's collaboration with Koidu Holdings, the response offered is like a reflex: "We Kono are just wicked."

Surveillance and Resistances

Bigger, the former rebel and confidante of the "aggressive" Koidu Holdings boss named "Dakhulu" was well known in Koidu's *djamba* ghettos. We met in a tucked away alley near the district hospital. He was a muscular man with a pockmarked face and squinting eyes, a husky voice and jittery intensity that may have come from his years fighting in the bush. Bigger worked within the company's internal security department, and told me that the company developed a network of "informants"—both local leaders and ordinary townspeople—who were put on the payroll of the internal security agency and reported possible thefts and protest plans. His work was much slower and stealthier than his years as a combatant, "just watching" the employees to

[20] In Kono, there are Paramount Chiefs who are remembered for advocating for their subjects amidst the incursion of extractive corporations, using local taxes responsibly to "develop" their communities, or even, protecting their subjects from rebel invasions during the war. But these are generally isolated, distinct memories that subjects attribute to the particular Chief's personality, leadership or commitments to his Chiefdom.

make sure they didn't steal diamonds from inside. At night, he said, he would monitor employees and intruders trying to steal little things like iron drums or buckets of tailing (the gravel that has already been sifted through once for diamonds, but inside of which there might be some smaller stones remaining.) Bigger felt that, in addition to the small salaries, the company's most egregious abuse was keeping the tailing guarded inside the mine.

> There are those people who are talking, saying, 'Those people are stealing from this company, [those people are saying] 'We have to attack this company, we have to fight these people, there is no benefit for us in this our country, in our homeland, we don't have any benefit, we have to fight people.'…
>
> When [the informant] gets the information about somebody that [wants] to fight the company, he goes and gives the information to [the chief of security], when you come in the morning hour, he just dismisses you. You don't know why...what is the problem— you don't know.

Ngaujah, Bigger's friend and another former employee, added:

> [Dakulu] has personal people that he recruited, and he is paying them--I don't know if it's out of the company money or out of his own money. And these people are in disguise, they don't have uniform. You can't even identify them— except maybe if you are here now discussing…when you go to the company the next day you hear [Dakulu] explain everything to you. And then your mind will start playing, 'Ok when I was saying this, this, this, this, these guys were around.'

In the coffee shops and *djamba* ghettos where I would meet these former employees, often with an audience of other embittered young men, I always wondered if these stories more reflected the men's own imaginaries of how a neo-colonial corporation staffed by former combatants would operate. But the company certainly benefits from the specter of conspiracy that these rumors of a corporate panopticon engender in disgruntled staff, and the ways these rumors build on peoples' skepticism of each other in an opaque landscape of political power and intentions. Eventually, even Bigger got fed up with the way the company "*dɛm lɔk di gem*" and

was sacked after being caught on camera stealing a bucket of tailing himself. “They were using the tailing to pave roads and dumping it in a big pile on the mine!” When he was caught, Bigger said he told the security officers: "You're not paying much money, I need money!" And that was that.

Ngaujah, a younger and quieter man, explained that he had worked for the mine as a store clerk, but after being held for months in a temporary position and paid only $50 a month he joined others in his department to organize a sit-down strike. The conditions and frustrations at the pathetic salaries had gotten so bad that the risk of possible mass-firings seemed worth it. They wrote a position letter to the company manager explaining their requests for contracted work and livable salaries, but received no reply. As they began the sit-down strike, the Minister of Mines and Mineral Resources came all the way from Freetown to negotiate with the company. But after gathering the workers, Ngaujah said, “He did not tell us any better thing, and we said, ‘This is rubbish.’” The protest spread outside of the mine, some men from the ghettos in town got involved and burned a nearby police post, and two young men were shot and killed by police under the supervision of the company. A crude, painted portrait of one of the dead now marks a central roundabout in Resettlement.

After the shooting, the Vice President, himself a Kono, was sent to address the situation and to calm the tinderbox of tensions. The strikers were optimistic that the Vice President would express solidarity with his fellow Kono and work to push back against the Sierra Leonean Government’s continued allyship with the Koidu Holdings company. A huge meeting in the central hall in Kono was organized with great anticipation, but when the Vice President met the angry crowd there, he began to shout: “*Sidɔm na grɔn! Una ɔl sidɔm na grɔn!’* [“Sit down on the ground! All of you, sit down on the ground!]” The strikers erupted into anger at this unexpected

insult.

As the "*siddon na grond"* story has been told and retold over the years in heated conversations in coffee shops and ghettos, some of the Vice President's Kono allies have pointed to a possible double meaning to the command. *"Siddon na grond"* is, in Krio, similar to the expression: "*Pɔ n'nɛni du bia*" in the Kono language. This expression means something like "squat on the ground," but is only recognizable to senior members of the Poro sodality. In certain moments during the Poro initiation rites, initiation leaders will boom: "*Pɔ n'nɛni du bia*," and only those who have not yet been initiated (and thus instructed in what the command means) will remain standing, humiliated. Seen in this way, the Vice President's yelling "siddon na grond" might mean something closer to "*let everyone who knows he is a member of the Kono society sit down.*" Perhaps, this explanation goes, the Vice President was doing his best to convey his solidarity for the Kono people in the coded language of *poro* collectivity, to convey that both he and the protestors were part of the same struggle that those outside did not understand. He did go out later that night and try to calm the tension on the streets alongside the protestors, after all. Maybe he was even instructing the audience to sit down as a collective, and to lay in wait for a more concerted uprising against the abuses of the mine that would yet come. As a revealing nexus of the layers upon layers of suspicion, convoluted motives, opaque commitments and cultural mystification that define so much of how the machinations of political power are experienced in Kono, people continue to read (and re-read) wildly different significances into that single episode in the wake of the strikers' murders.

But most in Kono now still insist that the Vice President had sold out by that time, and was more interested in the cash handouts he must have been receiving each month from the South Africans than the wellbeing of dislocated Kono and poorly-treated workers: *siddon na grond*

meant, quite literally, *shut up, you poor and irrelevant people, and sit on the ground.*

Ngaujah was sacked soon after the strike and replaced by one of the endless throngs of young men who are out of work and who are willing to take the precarious job. But Ngaujah smiled when he told me that the loss of employment was not too consequential: the following year, the Ebola epidemic erupted and he was able to cash in on the myriad jobs that suddenly opened up in the region for NGOs, burial teams, contact tracing and other frontline positions in the emergency response.

“They Have Killed Us”

On the dusty outskirts of the Koidu Holdings electrified fence, scores of women and children pick their way delicately down the large boulder slopes carrying pans of stones on their heads. The rocks are sorted into those which will be smashed into gravel by school-aged children on the stoops of resettlement houses, and the occasional kimberlite block that escaped the company’s processors which will be hammered by men squatting in cages made of mosquito netting, in case a diamond rolls out. Each time a new tributary of water bursts through the mine’s walls, young men arrive within hours to sift through the nearby gravel in hopes that a small diamond may remain in the runoff. High up on the rocky slopes leading up to the mine, one can barely make out dozens of young children studying the ground silently looking for a glimmer of reflected light that might be worth pursuing. Nearby, descending into the swamps adjacent to mine, amidst the buzz of its conveyer belts and trucks, women and men crawl up and down the near vertical cliff carrying stones, barefoot, looking like ants on a hill. At the top they sift these too into chunks Kimberlite and blocks of gray stone.

As I walked one day among the families smashing stone blocks on plastic sheeting, I stopped to speak with an older man who was hammering at little stones in a mosquito net. He had not seemed to have found anything in days. But he wanted to show me something—I could not quite understand what— and directed me over a gravel hill. Cresting the ridge, I saw a crater-like lake, overtaking what looked like a pile of wood bordering the Koidu Holdings' fence. The scene resembled a moon-scape: there were no trees other than a few scrubby bushes that had managed to penetrate the rocky ground. A large woman was yelling at an audience of other women, gesturing towards what I then realized was the ruins of a house submerged in the middle of the crater. Her name was Finda, and she was in the middle of telling the story of the loss of her livelihood.

Soon after the war, she said, a friend of hers had asked if she would buy a small pig. Finda bought the pig but was disappointed by its small size. So she put it in a room alone until it got big, and let it have one day with a neighbor's male pig. Soon, Finda's female pig had thirteen piglets. From there, her drove continued to multiply and eventually she had dozens of pigs. Finda became fully occupied with feeding and caring for them, and processing and marketing the valuable meat herself.

Representatives from Koidu Holdings had come some months back to tell her to resettle to a new place several miles away since the mine's expansion and continued blasting made her property no longer safe. But when Finda visited the land she was asked to move to, she was told that town bylaws prevented her from rearing pigs there. She raised her case with the Koidu Holdings team that was managing the forced resettlements, and she said that one South African man had been particularly impressed by her entrepreneurship and ingenuity and brought her leftover food scraps from the mine to feed the pigs. He said that they would make provision for

the pigs, but the plan needed to go through the Paramount Chief. When Finda went to the Chief, he showed her a place that was far away from her new resettlement house to keep the animals—but she agreed nevertheless. But then, the elders there told her they were planning on using the area for a sodality initiation bush, and would not allow her to move her pigs.

She went back to the South Africans, who again said: "Go back to the Chief." She became impatient: "This is your problem! I go to the Chief when I have a personal problem--you deal with this!"

A few days before I met her she had awoken her at 6AM. A massive gravel mound had burst and cloudy water from the Koidu Holdings mine had rushed out in a stream, flooding her entire compound. Forty-two pigs drowned, part of her house of mud bricks collapsed in on itself and the entire area was flooded. She buried the pigs she could find "mashed with the mud and dirt." The rest were probably still floating or had sunk to the bottom of the lake. Within a few hours, scores of miners had appeared to start sifting through the mud on the shores of the new lake, seemingly indifferent to Finda and her crisis. In the middle of retelling her story, Finda paused to turn away from me and the other women who had gathered to express sympathy to scream at a group of men on the far corner of the crater who had begun mining and had blocked the one outflow stream back into the mine's pit.

I was struck by the way Finda drew out the recollection of her slow work, over many years, of building the pig business, delaying the story of the evident crisis in front us. Her story included what seemed an almost awkward amount of detail emphasizing her efforts to expand the drove, develop a clientele base, to learn how to slaughter and process the pigs so she could extract the most value from the business. Michael Jackson warns anthropologists of Sierra Leone against "a Eurocentric idealism that celebrates action over inaction and sees the realization of

dreams and the gratification of desires as the consummations of the meaning of life" (116). For Kuranko-speakers in Northern Sierra Leone, he writes, "You cannot go out into the world and wrest good fortune from it. You cannot force your time to come. You must wait upon God's good time and graces" (115). But this wresting of good was precisely what Finda's story elaborated. And she wanted us all to know that. Unlike Peter, Finda had not waited for, counted on nor even referenced God's plan.

These pigs, labored over for years and now floating in the brown lake, paid for her children's school fees. *This* project and the slow work of building it up had transformed her from a petty fish-hawker to an effective agriculturalist. Over the years in Kono, I had heard NGO development workers comment that the region is a particularly difficult place to implement small-scale economic development projects aimed at increasing agricultural production, because rural peoples' sense of the relationship between toil and economic stability has been so distorted by myths of people striking it big through diamond mining (more on this below). Yet here was a woman precisely reflecting the entrepreneurial subject's teleology and methodical patience. There was a cruel irony to the fact that her long-term toil in the pursuit of an agricultural business was concretely, and instantly, erased by the diamond mining industry itself. Perhaps, to return to the Kuranko adage, Finda's *not* waiting for her time to come by insisting on the possibility of creating a stable future from scratch was the problem. If she had remained a fish-hawker, the sudden flood of her house might seem less catastrophic.

In the process of telling her life story, and as she got to recounting the flood, Finda became increasingly angry, shouting at no one in particular. She was waiting for a meeting with the Mayor a few days later, she said, but she was not optimistic. Then, her tone switched to a kind of depressed hopelessness. "They turn me so they turn me so they turn me so they turn me

so," she said of the many authorities she had gone to, each noting that her situation was out of their domain and referring her to someone else.[21] At times, I have been surprised, as I have heard stories of people "being turned so" as they seek to have a document signed, or compensation for property damage, when a week later they have followed all the leads and come back with the desired document, signed by a surveyor, the town chief, the section chief, the Paramount Chief, the mayor, the police, the Minister of Lands—satisfied, even if it cost them a pretty price.

But sometimes these crises of dislocation and instant impoverishment like that which Finda faced remain unfinished, unresolved, with nowhere else to turn. As Finda narrated her story, her situation seemed to slip into and out of order in real time. Finda oscillated between a resistant anger and protestation and a type of exhaustion or resignation at the hopelessness of her lot. She landed, in the end, at the latter. Signing, looking away from me and the audience, she muttered under her breath: *"*Here I'm from. Here I'll sit down… *Ehh, den don kill we.* [Eh, they've killed us.]"

Artisanal Miners

While in terms of the sheer scale of their operations, foreign actors like Koidu Holdings dwarf the diamonds mined out of shallow "artisanal" or "alluvial" mines, it is in these latter pits that the majority of men involved in Kono's diamond trade spend their days shaking gravel. Nearly every man in the areas around Koidu has spent a significant part of his life working in or otherwise

[21] As Achille Mbembe and Janet Roitman write, this dizzying dispersal of bureaucratic power is a common phenomenon in postcolonial Africa. "Every step or effort made to follow the written rule is susceptible to lead not to the targeted goal," they write, "but to a situation of apparent contradiction and closure from which it is difficult to exit either by invoking the very same rules and authorities responsible for applying them, or by reclaiming theoretical rights supposed to protect those who respect official law" (342).

involved with the mines. These muddy riverbanks, dug-out swamps and flats punctuate the landscape in all directions, with serrated piles of brown gravel surrounding the pits that, from a distance, look like crosses between an adobe village and a termite nest. Within these mines, the equipment is old and patched together, generator pumps belch out black smoke, mesh shakers are repaired with thread, and rusted shovels lie scattered on the banks. The alluvial sites are often named after the foreign companies that have mined the area in the past and which may have missed tiny stones during the days when the land was flush with diamonds. Lumps and hills in the landscape serve as a kind of archive of who mined in the past, and a repository of geological know-how about where the remaining deposits are likely to lie.

The work of artisinal mining is strenuous and at times dangerous. Since the location of the gravel is what ultimately determines the chance of success, miners go to great lengths to access gravel that is thought to be most flush with diamonds. Certain mining teams will swim deep underwater, held down by large rods, to access submerged gravel. Others will dig tunnels which can collapse and suffocate the miners. The sand on the banks of the rivers can also collapse, drowning miners. And even those who merely pan through the surface gravel stand for hours every day in schistosomiasis-infested mud and mosquito-infested air.

Depending on the scale of the operation, a generator-powered water pump may be used to wash off the dirt. Often, gravel is shoveled onto round screen sieves which are held right at the water level and examined for a glimmer. Though months can go by without finding a single stone, this work requires the utmost concentration for hours on end so as not to miss a small diamond. While experience might lead one to a sense of distracted futility—*what is the chance that this particular shovelful will have a stone?*—this is dangerous and must be overcome, as any shovelful is just as likely as the next to be the one that launches the miner's life out of poverty.

But the stones are few and far between, and most miners face economic precarity, and hunger, in between finds.

The economic and personal relationships that between financial backers, miners, and the Mandinko *djula-men* who either use their networks to get the diamonds out of the country or liaise with Lebanese who have the export license (or otherwise arrange for export) are complex. There are different general patterns to these relationships: the "master-miner" relationship, with the miner himself responsible for food, and equipment, with a 50/50 split on the proceeds of the diamond; similar arrangements, but including a small stipend for the men in the pits as well; or a purely wage-labor agreement called *Kosovo* in which miners are paid a flat rate per day regardless of whether they find a diamond. Some people work for themselves, mining a small plot through an informal arrangement, and sell the small diamonds to someone with a license who can fold them into their own loot because each exported diamond must be sourced to a license. Interestingly, the Kosovo arrangement in which laborers do not receive more money for a successful find, the only one that guarantees a stable wage for the workers (while making the laborers entirely alienated from the fruits of the labor in the Marxist sense) often evokes the strongest feelings of exploitation among those with whom I spoke. "Kosovo," a Mines and Mineral regulatory Officer once told me, is "a *very wrong concept*."

Some anthropologists and development have characterized the "mindset" of artisanal miners as akin to gamblers (Levin 2006) or obsessive lottery-players, "who, week by week, fail to draw a winning ticket find themselves more and more abandoned and yet addicted to the harsh, asocial way of life of the pits, hoping that yet one more week might result in that big find" (Richards 2001:73). Others have problematized this analogy, as both blaming the poor and their

psychology for a set of structural conditions that artificially inflate the stone's value through monopolistic control of the trade (D'Angelo 2015) and also effacing the very precise forms of knowledge on which miners draw to target diamondiferous areas. But artisanal miners often described their own work to me as a type of unsatisfying but nevertheless seductive labor of gambling. In any case, the miners are proud to have the "chance" to work hard, make an effort at something and to have the possibility of honestly earning money—especially in a context with rampant unemployment, other forms of "true" gambling such as sports-betting that do not involve hard labor and are looked down upon, and a phenomenology of crushing boredom that drives young men to engage in informal economic activity just to have something to pass the days (Quayson 2014:244).

Past Luck; Present Poverty

"Diamonds were plenty— *dɛm bin de kɔmɔt!*" a middle-aged man named Mustapha told me on the outskirts of Koidu. He spent each day in a mud swamp with his shaker. He told me of his early childhood with his family in the center of the country. Though they were not desperately poor, his father, a farmer and trader who traveled back and forth from Dakar to sell clothes, worked hard to pay his school fees in both English and Arabic academies. A group of friends told him: "Listen boy, while you go to school, we're finding money! You see, you come dig diamonds and it's money!" Mustapha said he "didn't even say goodbye to my family—I just moved, I just went!"

During those early years, when diamonds were plenty, Mustapha said that he "had luck!" His father tried to pull him back to school, but in a major conflict, Mustapha decided that "this Pa—I'm not going to be able to live by his word. *I left him and went to dig diamonds….*Why? Let me tell you about diamonds. That time, there were plenty of them. If you go, you get. Every day I found them. They were plenty! My father beat me, my brother beat me to go to school." But eventually, his father told him: "'If that's what you want, I'll leave you to it.' So he stopped beating me. The diamonds were sweet to me!"

Many of the miners I met began their stories begin this way. An intimate and bucolic portrait of agrarian family life is recalled as preceding the allure of the diamonds and the money they brought with them. Yes, the diamonds were plenty—or at least, remembered as being plenty— but they also prompted the erosion of family ties. But the seduction of the diamond and the loss of agrarian family life prompted a kind of nervousness and foreboding more than an immediate dissolution. Mustapha's memories of that time were sweet: he got married as a young man and had several children. Life—his own life— looked up as he devoted himself fully to the enterprise: "If I heard the news that a new opened up in Tongo, I went there!...I told my family 'goodbye' and I went." He told me about the day that he found the biggest diamond he ever saw. That moment when a glint of light is visible in the sieve is difficult for miners to describe. The word most commonly used to describe the surge of emotions is "shock" (D'Angelo 2014:276). Mustapha saw it in the shaker—"it wasn't too bright—like a candle color"—and times were sweet after that. From that diamond, "I did a lot of things for my people." The diamond, in other words, fed back into strengthen his relations with kin and the family home. This was not a simple story of a commodity destroying traditional agrarian life-ways.

When recounting these prosperous years, the miners express no clarity about what exactly the diamonds were used for, nor why they continue to be so desired. I heard vague allusions to industrial uses, helicopters, car windshields, but never reference to jewelry. But there was also little interest in this question. I once asked Mustapha: "You don't know why the white people want the diamonds—what would you think if one day they stopped wanting them?"

He looked confused for a second, then said: "They've wanted them for 80 years! I'd wait, and hold onto my diamond—of course they would want them again! They have their reasons!" Artisanal miners in Kono diamonds speak of the diamonds as having no use value, but only an exchange value—they *are* money (see also D'Angelo 2014). Mustapha got married, did a lot of things for his people *from that diamond*. Mohamed, another miner nearby, told me of the time that he "built a six-room house from *one diamond*." Money is not even a mediating substance in these narratives—the material essences of a stable and comfortable life are directly emergent from one's luck in the mine, from the piece of glimmering but use-less rock that one stumbles upon.

I have never heard a miner say that he is able to answer the question: "How much do you make in a week?" Such a question would suggest that this work is akin to other occupations in which one's labor is rewarded through a regular and accumulating compensation. One older man mining nearby told me: "It's left to God. It's left to God. Sometimes it takes one month and I see nothing." Another told me: "Diamond work is not an *everyday get* business. When you follow diamonds like for three for five years...when you continue, maybe God will be sorry for you, maybe you will meet up 5 carats, you go and sell it for 50,000 dollars? Or 90,000 dollars! Straight away I will have finished work. So right away then you've 'covered up' those five years

when you didn't see any diamond. Then I will take a plane to go find a job in Germany! I will find a job in South Korea!"

These stories draw out the peculiar relationship of labor, time, contingency and material stability in the context of Kono's mining economy. They are strikingly different narratives than that which the woman told about her pigs, or the stories the miners tell of their agrarian lives before the diamond boom. Wellbeing for alluvial miners is secured in leaps and bounds, manifested through conspicuous consumption and the material transformation of personal and domestic life, punctuating months and months of fruitless toil. This trajectory towards a future is not, and cannot be, predicted.

Stories still circulate about people stumbling upon life-changing diamonds today (Hardin 1993:25). Interlocutors in Kono often interrupted conversations as we strolled down a dirt road in the aftermath of a rain; putting up an arm to block me, they would step back, to the side, examining a glitter they think they saw in the dirt. After these early rainstorms, when a layer of mud has been washed off the rutted roads, people walk with their eyes to the ground. In 2017, even the international media picked up a story about a Pastor in Kono whose mining team came across a 709 carat diamond, hockey-puck sized diamond, the 13th largest ever found—perhaps worth over 50 million dollars. Outside of Kono, the Pastor's decision to turn the stone over the Government served as a sign of his patriotism and how much the political situation in the country had improved since the war. "Momoh told The Associated Press that he turned in the diamond because he was touched by the development being undertaken in Kono District, where the gem was found," Fox News Reported. "He cited road construction and improvements to electricity after almost 30 years of blackouts" (Associated Press 2017). Within Kono, the debacle that unfolded was retold with uproarious laughter. "The guy got Chief Sumana involved, then the

President, and whoop—direct out of Kono," a colleague told me with a wave of his arm when we spotted the Pastor riding along a dirt road on a beat-up motorbike. "Who knows where it is now. The Pastor didn't make a cent!"

The Devils

Many of the miners I met did not even stop their shaking and sifting to be interviewed. My recordings can be hard to make out, over the rustle and rhythmic gravely sounds of dirt being slapped around the sieve. And many men seemed so deeply impoverished and desperate to find a stone that they were not particularly inclined to tell me the myths and esoteric practices that I had read so much about surrounding the diamond mining trade. But a few did mention the devils who live under the sand and water, protecting the stones—*djinns* or spirits or trickster figures who at one time must have been dismissed as just "devils" by a European missionary. Devils often appear to miners (usually in dreams) as miners unearth new land, signaling danger, frightening them or demanding a sacrifice. Devils are protective of land that they inhabit, including the diamonds contained therein.

It is tempting to consider the relationship between these occult figures who must be managed with sacrifices, charms and consults with *morimandem*[22] and the outrageous amounts of wealth concentrated in the form of useless stones, as a sort of mimetic and symbolic projection of the anxieties, mystifications and suspicions surrounding commodity capitalism—an example of what the Comaroffs would call the "occult economies" of millennial capitalism (Jean

[22] A *Krio* term for a specialist in magic, particularly those reliant on techniques of Quranic healing and other Muslim forms of healing and apotropaic protection. "*Dem*" as a suffix denotes plural.

Comaroff and Comaroff 1999). But there is also something to be said about the devils and the particular nature of contingency in the mine. D'Angelo notes that the ritual practices that the miners conduct to mitigate the risks of devils are oriented around appeasing and engendering mutual trust, not mastering, diagnosing, exorcising or extracting the devils as one might do with a witch. He argues that this reflects a broader way in which artisanal miners learn to navigate networks of human and non-human entities—and the substantial natural perils involved in the work. "Diamond mining is based on continuous negotiations and compromises between the certain and the uncertain, order and disorder, or the familiar and the alien" (D'Angelo 2014:286). This tenor of balance, of wading into uncertainty, of putting your faith in an inherently precarious occupation is reflected in the miners' ritual relationships with the devils.

I arranged to meet a well-known medicine man known for his ability to foresee miners' luck. The old Kuranko man lived in a dank, thatched hut in the middle of town, lined with trinkets, amulets, Quranic tablets and bottles of liquid. The old man said that he first learned Arabic writing and began to see patients for all sorts of maladies by washing a *surah* from a tablet and providing the liquid to the patient. But many years back, he began to be visited by two devils himself, on Mondays and Fridays. They just appear, he said, "Like you are sitting there now." He offers them rice and white flour the days before they come—it's always gone in the morning—and provide answers to his questions and direction about what herbs and leaves to offer patients.

> When I tell you about your own program, concerning diamonds, concerning any kind of work I'll say: 'Go wait until Monday or Friday when I'll ask the devil.'
> When I see the devils, they will say: 'Luck isn't there on the diamond work'.
> Or they'll say 'The luck that you have, your luck is there on the diamond work.' If your luck is on diamond work, I'll tell you, and you will get a diamond.

The man, or rather his devils, were not offering to *intervene* to increase miners' chances of finding a stone. This was not sorcery, nor really medicine, but more akin to soothsaying. I had thought that these explanations of devils hiding the minerals would also provide a space for managing and intervening in the arbitrariness of what one can earn in the alluvial mines. I asked the man again: are the devils able to *put* the diamond in someone's sieve, to change their life, to give them a chance?

> Devils don't have diamonds. Diamonds are in the *djula's* hands, and come through God and his senses. So how you find diamond is this: the devil says you'll find a diamond…he'll say: *luck's over there, go there!*
>
> There are different types of devils—like how this man here is black, and this one [pointing at me] is yellow. Some devils don't have much, they're poor. Some devils will follow you, and they'll see a diamond inside a shaker, and they'll take it and put other stones inside that look like a diamond. Some devils are thieves!

In other words, the devils are limited in how much they can actually help, even when they trust the miner. Like the Igbo protective spirit in Chigozie Obioma's novel *Orchestra of Minorities*--and, to some extent, like the American former volunteers who Peter had written asking for help and assurance after Solomon's death— the devils can *see* but they cannot *change* what is hidden beneath the surface. It is worthwhile to patronize the devils, to protect yourself and maybe to learn whether or not you can expect luck. But it all remains a matter of luck. The *moriman* almost sounded like he was admitting his own inability to alter the random nature of artisanal mining, and kept pivoting back to his more substantial knowledge and practice of medicinal cures for illnesses.

At the end of our conversation, he insisted that diamonds were still plenty in Kono. "Diamonds are there. Except if a witch gathers it and gives it to a devil to keep. If you don't have

a clean heart, if you aren't straight, if you aren't honest, you won't get one," he said. "If you steal from your master, if you steal from your supporter, if you speak a lie to those who help you out—you won't see diamonds." I left wondering whether this *moriman*'s prophecies served more to encourage his miner-clients not to give up hope, or to reinforce a sort of moral code for all the actors involved—desperate for money, increasingly frustrated by the depleted surface diamonds, often in intensely exploitative relationships—than to provide a way for miners to manage the arbitrariness of the whole enterprise.

Regret

In the narratives of the alluvial miners, there's always a pivot in the story after recounting the flush years of the 1970s and 1980s, when Kono was the "Paris of Africa" with streetlights, Mercedes-Benz cars buzzing around, beautiful Lebanese women coming for vacation. The pivot is to a tenor of regret.

Mustapha, for instance, continued his story: "This diamond business…I don't feel good about it, I'm not going to lie. Because why? The ones that I went to school with, today, some are doctors, the women are nurses, and I had more sense than them!" The regret seems to build on itself: "If I tell you today I'm well, I'm lying….My heart has broken for this diamond."

The alternative to a life spent in the pits is always portrayed as one of farming, which is framed as a more moral, responsible and ultimately lucrative occupation. And most miners do have small subsistence farms which supplement the meager amounts they make in the mines. But to farm at the scale that would be required to substitute for the pursuit of diamonds would require

startup costs that are simply unavailable. “Agriculture work takes money, but the Government is not interested in people,” Mohamed told me. “The thing about diamond work—I can do it for myself.” Furious at what he saw as the rampant corruption of donor “European dollars” for government-run agricultural projects, Mohamed framed the mining as an assertion of his own autonomy from and his skepticism towards the postcolonial, patrimonial political system.

These narratives of regret are not necessarily windows into history per se. “It is a universal human failing to think that the world is a happier place in the past, and that things have fallen apart since one is young,” Jackson writes. “Undoubtedly, this idealization of the past is born of present dissatisfactions and reminds us that well-being is less an attainable goal than a necessary fiction without which we might conclude that we have little to live for” (38). Nostalgia, in other words, is perhaps more a life-affirming force than a reflection of an actual change in historical conditions. Most miners could—and do—engage in agricultural work as well, and mobilize networks of resources and kin to fund and labor on joint plots.

Furthermore, Kono has been a nexus for extractive activities, but has also served as a case study in the perils of the extractive economies—a testing ground for theories on the Resource Curse that dooms mineral-rich African companies to political collapse, on decrying the “gambling mentality” of the poor, and for romanticizing a (perhaps) imagined simpler and more stable African agrarian past and alternate future. Mustapha may have been interviewed before, by journalists, anthropologists, or NGO workers working with programs with names evoking the mineral economy and what might replace it, like the World Bank “Life After Diamonds Project” that has built community meeting-grounds across the District (as if what is lacking in the region is the material infrastructure for social cohesion).

But most researchers do believe that surface deposits in Kono have dramatically decreased.[23] In the wake of an extractive industry boom, people can be left with both deep impoverishment and a general malaise, nostalgia and sense of abjection from the collective let-down of the unmet "expectations of modernity" (Ferguson 1999). The region is saturated in these narratives of contemporary regret, frustration and bitterness juxtaposed with a nostalgia for a past of luck, good fortune and, more than anything else, a future with promise. As Mustapha said, "Tomorrow, if sick holds me, will I not die? If I did agriculture, I'd have money in the bank. If I was sick, I'd got to the hospital. But [with] this diamond, you don't have anyone to help you."

Conclusion

In some sense, these narratives are evocative of Sigmund Freud's concept of melancholia. For Freud, ordinary mourning turns into a pathological state of melancholia when a lost object is not, over time, let go of but is held onto in a way that "self-torments". There is no conclusion or transcendence to melancholic mourning. There has recently been anthropological interest in the ways that melancholia may be read as something of a collective cultural order in the wake of settler-colonialism for populations that have been dispossessed of the land that formerly offered sustenance and cultural territorialization. Anthropologist Angela Garcia, writing of Hispanos in New Mexico who live surrounded by land of which they and their ancestors have been dispossessed: "One wonders how Freud's conception of melancholy can be extended to address such material losses, losses such as land that remain present but out of reach, especially in a

[23] Experts I interviewed from De Beers' believed that large quantities of diamonds remained to be found.

context"—one, I might add, that has great resonance to the situation in Kono— "in which land is constituent to cultural identity and economic survival (Garcia 2010:83–84).

Lauren Berlant, on the other hand, offers "cruel optimism" as a structure of affect that is related, but critically different than, melancholia. Rather than the subject mourning the *loss* of a singular object, "Cruel optimism is the condition of maintaining an attachment to a significantly problematic object." That object can be a fantasy, like a shared and propulsive image of the Good Life: "[I will get] 90000 dollars….I will take a plane to go find a job in Germany! I will find a job in South Korea!" Cruel optimism, unlike melancholia, is a forward-looking state, evoking people's desires even if that which drives the subject's movements (the seductive promises of the mines punctuated by a sense of "stuckness") is in fact an obstacle to flourishing.

Peoples' attachment to mining in Kono occurs for many reasons, not least of which is the lack of alternative sources of survival. This is a material as well as an affective peril, though as Berlant notes, these two forms of cruelty are in many ways inextricable. Furthermore, this aspiration for the "Good Life" is not merely phantasmic, and the diamonds are not wholly lost objects: small stones do continue to appear in tantalizingly sparse numbers, big players continue to seize concessions which drive new scrambles for tailing, and some, very few, miners describe achieving a good, middle-class life through the hard work of shaking in the pits every day, some make it big.

Most small-scale miners know the stones are largely lost, and yet the work feels inescapable. The promise of life-making wealth remains omnipresent, *it* is still *there*, even if the possibility of achieving that promise in a lifetime that itself is so hard to predict it feels increasingly foreclosed. The miners continue to try and manage the contingencies of the trade, from drawing on historical knowledge of past productive mining sites, to recognizing the

geological characteristics of promising gravel, to relying on ritual activities—hiring *morimandem*, carrying out animal sacrifices, consulting the spirits and devils who protect the stones underground and underwater. But in the ways these efforts are described, they never seem wholly adequate to mitigate the chance of it all.

In the past, there was luck, but there seemed to be a plan to it, one that the miners came to study, to master, to know. Now, whether one stumbles across a stone and thus secures food for the month seems somehow more arbitrary, and this too must be lived-with. The miners work diligently day after day, but their stories convey a general, if unstated, acceptance that while they inhabit a space proximate to world-changing amounts of wealth, the most likely outcome of their work is a stable state of poverty. How does one orient one's life towards—or *live* towards— a future, when whether one earns enough to fly to South Korea, to build a six-room house, to leave something for one's children, to have enough for medicine or just to buy the next weeks' worth of food can neither be controlled?

Like Peter trying to wrap his around his young brother Solomon's death, the adversity Mustapha now faced was not surprising—and yet that did not necessarily make it, phenomenologically, any easier to bear. Having watched the possibilities of a prosperous future increasingly seem to recede over the course of his life, Mustapha, unlike Peter, no longer even invoked an explicit order to it all. The expression that he used to describe his present predicament was not *na God,* but the slightly different: "*only God knows."*

Interlude: Illusory Global Health

Elizabeth and I had hopped over trash-strewn sewars, rickety old foot bridges and alleyways made of rusted zinc as she showed me her neighborhood in Freetown. I had grown close to her and her children when she was the caretaker of a house I stayed at, and she wanted me to see the place where she lived. Elizabeth had managed to make a clean and comfortable enclave in the house she rented, with a DVD player on all the time and several fans keeping the relentless heat out. But outside, the filth was everywhere: the ground seemed like it was made of layered plastic bags and dirt, letting out little squeezes with each step. “This place is very bad for children!” she kept saying with a big smile on her face. Elizabeth took some pride in her toughness in living in the neighborhood but said if I ever brought my own children to Sierra Leone, she wouldn’t think of bringing them here. She swept her hand towards the corrugated zinc shacks jutting out into a mangrove swamp: all flooded from time to time with the rising sea level. This was a reality I had heard NGO workers talk about more and more, since each of Freetown’s slums spill out into the city’s bays. In one infamous slum, an international NGO had put up a sign that simply declared that the area was flood risk—for what purpose was unclear— and displayed the logo of the NGO underneath.

On our walk, I suddenly found myself facing a massive, glimmering well, tank and spigot structure that looked unused. It was painted navy blue, and towered over the rest of the houses, with several solar panels on top. A sign was plastered outside the gate: “FUNDED BY THE AMERICAN PEOPLE.” Earlier, Elizabeth had complained of the long trips she had to take every morning to a broken pipe where water leaks out to fill up her bucket for her family’s showers, and I asked her what she made of this donated infrastructure. She furrowed her brow

and shrugged. It seemed that she had never even noticed the plumbing system before. These one-off, uncoordinated pieces of infrastructure materialize in neighborhoods like Elizabeth's so arbitrarily, but also so regularly, that perhaps she really had not even *seen* the well. In any case, Elizabeth did not know who had the keys, had not heard who could use it. "We just have no idea," she said, almost as a question and shrugged, and continued to show me on.

New World of NGOs

In Sierra Leone today, the NGOs and, as people in Kono put it, "*the people overseas, the donors"* have such a central role in the political, healthcare and infrastructural landscape of the country, it is hard to imagine what this world would look like without them. But a particular set of contingencies led to this situation (that resembles that of many countries across Africa). Beginning in late 1960s, the postcolonial Sierra Leonean economy began to collapse. The Siaka Stevens' administration sought to expand indigenous food production and diversify the economy (Kup 1975:218), but the 1973 and 1979 oil crises further compounded the country's economic woes. Within Sierra Leone, falling export cash crop and diamond prices and the lack of industrial development dramatically reduced public revenue and flows of foreign money. Political instability, inadequately designed and resourced public institutions inherited from the colonial period and poor management of the economy led to devastating hyperinflation.

With little cash to pay for public services including the public health system and civil service salaries, in 1979 the Sierra Leonean government turned to international financing institutions for loans. Between 1979 and 1986 the Sierra Leone Government took out a series of loans from the International Monetary Fund (IMF), all of which were eventually abrogated given the government's inability to pay back the debt (Zack-Williams 1993). In 1986, Sierra Leone

began a long-term negotiation with the International Monetary Fund (IMF) for a Structural Adjustment Loan. In line with what would come to be called the Washington Consensus, these loans had major strings attached: they mandated dramatic reductions in public expenditure and civil service workforces, alongside renewed efforts to privatize various sectors of the economy and public services, and increase foreign investment (Kentikelenis et al. 2015). Through the 1980s and 1990s the Sierra Leonean Government spiraled into stunning degrees of financial precarity. The Government took on increasing amounts of IMF debt to prevent the country from entirely collapsing. The debt, unstable public service salaries and critical lack of cash in government coffers situation led to an explosion of shadow state and other illicit economic arrangements throughout the country. In one illuminating example, for instance, the Sierra Leone Government was unable to garner the funds for the fuel waiting on a ship in the Freetown harbor. So the Government released an Israeli diamond magnate who had been arrested and jailed for "economic sabotage" the month beforehand, and allegedly secured his private financing of the ship fees in exchange for his ongoing freedom and access to diamond flats in Kono and elsewhere (Reno 1995:165). Later, the government contracted a mercenary agency to fight back rebels and likely paid for it with the rights to the Koidu Holdings diamond mine (as described in Chapter 1). As in the colonial period, when the state was similarly cash-strapped, the work of governing in rural peripheries, particularly in diamondiferous areas like Kono, continued to be outsourced to customary rulers who devised their own revenue-generation schemes (Wilson 2013). Much of the architecture and machinations of this debt-fueled shadow state remain intact today.

As the Sierra Leone civil war broke out in in the early 1990s, the already-underfunded healthcare system deteriorated further and many physicians and healthworkers departed the

country. Osman, the Sierra Leonean physician who founded Ichende International was the only one in his class and the two surrounding it to remain in the country during the war. And it was in part these particular conditions—a hollowed out public health system and a humanitarian crisis during and in the wake of the war—that led to the explosion of NGOs across Sierra Leone in the early 2000s. This "republic of NGOs" (Farmer 2012) may not have been the thriving private sector of public services that the Washington Consensus experts had hoped would emerge with the liberalization of markets and the reduction in social programs—but if a health sector could be largely funded through economies of donor compassion, this would not interfere with the IMF's neoliberal strategies. The Sierra Leone Government sought, at least nominally, to keep records on who was operating what where, but humanitarian flows of resources and programs exceeded the state's capacity to regulate the hundreds of autonomously operated organizations. Soon Sierra Leone—particularly the rural hinterlands—came to seem like the wild west of humanitarian healthworker workshops, school-constructions, well-buildings, research agendas, randomized control trials on economic interventions, child-sponsorship programs, surgical mission trips, medical supply and technology donations and occasionally, sites of clinical care, all performed with little predictability or oversight and bound to the fleeting temporalities of one-off-grants and donor whims.[24]

[24] The "humanitarian reason" which underscores these contemporary global health interventions, Didier Fassin writes, fundamentally reconfigures the structural and the political as matters of morals, charity and compassion directed at individuals (Fassin 2011:2). And this political reason filters down into the places that constitute its objects, into the ways people learn to speak to and treat each other, in which care comes to be understood as meted out via whimsical, unpredictable flows of affect. There is much to critique about the fallibilities and exclusions of this humanitarian reason (see, e.g. Ticktin 2011; Polman 2011). But in this dissertation, I remain focused more on the actual in Kono: on what these peculiar logics of international compassion have *done* both to infrastructures of healthcare, but also to living, dying, care seeking and futurities in an archetypal staging ground for the humanitarian gaze.

Kono's Public Healthcare System

Even amidst this new landscape of non-governmental service providers, the public healthcare system today persists—a network of approximately 40 clinics across each district, and one central Government Hospital—but in many ways this is but a shell of infrastructure, on which transient donor-driven programs are projected, alongside triumphant (if fleeting) commitments and accompanying public health mandates.

In 2010, the Sierra Leone Government announced the Free Healthcare Initiative, guaranteeing free care for pregnant women and children.[25] This ambitious announcement drew a great deal of NGO programming to "support the Government's efforts," often in the form of supply donations and a whole lot of workshop, health outreach and training programs. But most clinics have remained chronically out of medications, and those that have things in stock often receive them via unpredictable donations ultimately originating from supply partners like Unicef and the Global Fund. Donated medications, bednets, and nutritional support can easily be found for sale in the Kono markets as well, siphoned off at some point down the pipeline. Until Alliance for Health Justice began hiring and managing increased staffing for the Kono Government Hospital, there were only two doctors for a population of 550,000 people. On the

[25] President Earnest Bai Koroma was hailed as an iconoclastic leader for this ambitious announcement that seemingly flew in the face of post-structural adjustment dogma.(Donnelly 2011). However, Sierra Leone had twice in the prior decade announced that user fees would be abolished. Both times the initiative had quickly fizzled as healthworkers continued charging for services to make up for their low and delayed salaries and the ongoing empty pharmacy shelves. Even after Koroma's announcement, the British Government donors held off on offering significant support until they saw a commendable degree of financial "commitment" from the Sierra Leone President. Several weeks before the initiative was set to launch, healthworkers went on strike throughout the country to protest the working conditions and unlivable salaries. Eventually, President Koroma authorized an increase in salaries, and this caught the donors' attention. This commitment of Sierra Leone Government funding had a "carry-on effect: donors, seeing the government commitment, increased their funding. DfID led the way, committing $16 million over 5 years, and $8 million for drug and supplies over the first year." I suspect that President Koroma knew all along that he had to find a way to perform his investment in the program and thus inspire multi-million dollar commitments. "We had to announce [the Free Healthcare Initiative] internationally," Koroma said, "and we had to do something to capture the attention of the donors and the people of the country."

ground, the NGOs have not necessarily *replaced* the public healthcare system, but do fill in the bare-bones infrastructure in unexpected morphologies, collaborations, negotiations and para-statal arrangements (Geissler 2015).[26]

The courtyard of the Koidu Government Hospital is an archive of these NGO-state arrangements over the past twenty years: a rusted ambulance, painted with the name of a diaspora humanitarian group, sits with flat tires on the gravel. Signboards for brief trainings and workshops lean against always-locked doors, and broken American medical equipment—often discarded by American hospitals as overseas "donations"— collects dust in corners. I often wonder how these one-off NGO engagements were received affectively: did they truly evoke promise or possibility? Did anyone ever drive the ambulance before parking it at its permanent grave, or were these always already ruins, "remains of enduring temporariness"? (Roth 2019).

Scholars interested in how contemporary Africans conceive of public healthcare system in the wake of the postcolonial political and economic collapse often draw through lines from the unfilled promises of post-independence biopolitics to the ways people look upon decrepit West African health infrastructure today (Geissler 2015; Benton 2015). But Kono's healthcare system, as anthropologist Emmanuelle Roth writes, does not trigger affects of "nostalgia or regret." Rather, as demonstrated by the courtyard of the Koidu Government Hospital, it resembles more a kind of exo-skeleton on which various NGO interventions are hung and staged. As Roth writes,

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[26] Alongside the proliferation of NGOs, there other distinctive features about this "Global Health" era, defining it as distinct from earlier iterations of international health politics, (and all in one way or another rooted in its neoliberal origins): the pursuit of forms of "generalizable" and quantitative knowledge on global health program, leading to a new "science" of global health implementation (Crane 2013b; Adams 2016a; Cal Biruk 2018); a presumed definition of access to *healthcare* as equivalent to access to *pharmaceuticals* (Biehl 2007); and the increased role of semi-private mega-institutional funders like the Global Fund and the Bill and Melinda Gates Foundation in sponsoring not only distinct programs but entire systems of clinical and public health. The subfield of "Critical Global Health Studies" has emerged as an offshoot of medical anthropology, offering critiques of the possibilities and limits of Global Health practice today, its problematic histories and legacies, its unintended consequences and the people-centered complexities that global health programs may miss on the ground.

all this quite clearly reifies peoples' certainty of "a regime of global health that stopped dreaming of grand improvements to health," (Roth 2019) one that has replaced aspirations for robust public services with the intrinsically transient models of NGO partnership and one-off donations of infrastructure, clinical care for behavior-change programs, and the logics of cost-effectiveness above all else. A walk from one ward to another amidst this archive of "half-built ruins" (Tousignant in Geissler et al. 2016) attests to the lived experience that any one NGO program—bound by the intrinsically transient models of donor-driven support— will likely not change much in the arc of a career as a healthworker, the health facility or, in all likelihood, the life-chances of a patient in the hospital wings.

The Politics and Anti-Politics of Global Health NGOs

In late 2021, as I walked the two or so miles into Koidu from the suburb of Koikoyima, I counted no less than thirty-three signboards naming various donor-funded projects just on the main highway alone. These signs were in various states of decay: often rusted, crooked, faded and neglected. Each was painted with the Project Name, Implementing Partner, Beneficiary Population and NGO or Bilateral Donor. Very few referenced donations of actual infrastructure ("Promotion of Sustainable Wash Management Structures in Sierra Leone); some more signs contained messages and childlike cartoons for parents and patients ("REIMAGINE POSITIVE PARENTING, CAREGIVING AND NURTURING FOR GOOD MENTAL HEALTH! (unicef)" or "CIVIL REGISTRATION IS A RIGHT AND A MUST!! LEAVE NO ONE BEHIND! (Irish AID/UNDP)"). The majority of these signs named more abstract, jargony goals (DIVERSIFYING AND BOOSTING LIVESTOCK PRODUCTION IN SL (Koakoyima Camp

Youth Organization/Oxfam/ChildFund/Sierra Leone Animal Welfare Society). This last category of signs, which often seem in particular neglect, usually referenced short-term training programs for farmers or other community-members. I have never seen anyone in Kono study or reference what they learned from these signs. They just appear, almost as a part of the environment, and then erode.

It is often surprising to visitors to Kono who have never visited such a ground zero of global health implementation to find that, despite the very evident forms of material suffering in the region—namely, insufficient food, soaring unemployment and abysmally under-resourced medical care—much of the NGO work one sees on the ground does not even claim to provide poor people with material support or even deliver any services. Of course, at a high level, bilateral aid agreements feed funds into sparse government coffers, and some few NGOs (like Doctors Without Borders, Alliance for Health Justice, and various religious groups) operate health facilities that deliver care to the sick (sometimes charging user fees). But most humanitarian global health programs that people living in Kono witness and interact with on a day-to-day basis do not provide any material aid. It is these programs, which, in good neoliberal fashion, always claim to beget more impact than the money that is invested in them, that at times seem to operate more at a register of performativity than humanitarian care: "trainings-of-trainers" on hygiene or referral systems; health-behavior jingles on the backs of pickup trucks; youth-group "launchings"; health promotion campaigns imploring people to wash their hands nevermind the fact that the plumbing systems needed to enact them have never been built; public health cartoons and messages dotting every few hundred feet deep into forested villages, where the majority of the inhabitants may be illiterate and certainly will likely not be swayed by a dancing portrait of "Mr. Condom Man."

Anthropologist James Ferguson (1994) has argued that the contemporary field of economic development reconfigures problems of resource distribution and structural inequities into technical problems the beckon technical fixes. The "anti-politics" machine continues to be an extremely helpful analytic to make sense of what one sees in Kono today: piecemeal donations of infrastructure, tweaks in national-level health policy a whole of training programs for population that are, and will remain, subject to extreme structural violence and vulnerability.[27] But this critique may suggest more analytical or ideological coherence to this space than one sees in a place like Kono, when the structural and material causes of people's suffering are constantly in view. There is something utterly bewildering about having a conversation at a guesthouse in the morning with a British aid worker who, after so articulately describing the tragedy of rural Sierra Leone's post-war reversion back into extreme impoverishment, the slim prospects for work, health or hopeful futures that young people in the country face due to the terrible state of the economy, enthusiastically speaks about the portfolio of traditional African "discussion trees" he is overseeing in a rural villages that will "repair" social cohesion and thus kickstart development.[28] How does a well-intentioned European humanitarian take a tour of one of Freetown's notorious slums, in which the stench of open

[27] Quasi-NGO/research institutions like Innovations for Poverty (IPA) contribute academic chops to this landscape of anti-political humanitarian interventions. IPA's researchers have implemented dozens of randomized controlled trials in Sierra Leone that attempt to experimentally identify the determinants of impoverishment, poor health, political upheaval and low rates of uptake of clinical services through tinkering with precise variables: how a message is communicated, for instance, or, in a recent study, whether incentives in the form of colorful bracelets might make mothers in rural Sierra Leone more likely to get their children vaccinated. (Presumably they would "socially signal" the mothers' compliance with vaccine recommendations to their peers) (Innovations for Poverty Action 2017). These interventions—even perhaps the bracelets—may indeed have effects on real people's lives: technical fixes can be a form of care. However, international trade policies, the impact of spiraling sovereign debt on Sierra Leone's capacity to implement pro-poor programs, untaxed diamond mines or even stocked-out clinics are almost never the object of focus (see also Richardson, McGinnis, and Frankfurter 2019).

[28] This types of community repair programs also often draw on racialized assumptions of rural African collectivism that need only be "restored" with donor funds.

sewage is overwhelming, nearly every child has the bulging abdomen of protein deficiency, and people's shelters are made out of sweltering, rusted tin leaves, and come to the conclusion that donors' money is best spent on a youth group workshop celebrating the need for "awareness about the negative impacts of the climate crisis" rather than a toilet system, food support, or simply better housing? Who would come up with the idea that a charity's money should go to a billboard over a crowded slum that spills out into a river filled with trash and foraging pigs, that simply declares that the neighborhood is a FLOOD RISK—as if that is not known to the people living there? This does not just seem a conniving neoliberal project that mystifies the political economies of impoverishment, even if many of these programs defy common sense.

Global health in Kono today seems to be constituted at times by an order of vacuity, a kind of half-baked nihilism, or something akin to what Guillaume Lachenal calls global health *bêtise*. This term is translated by Noemi Tousignant as "reason at its most arrogantly assertive," (Lachenal 2017:13); a kind of very active stupidity, the flipside, the positively-inflected version, of nihilism. Lachenal writes:

> I see *bêtise* as a particular species of unreason, radically distinct from error: an enthusiastic and enterprising form of stupidity, a confident and calculated form of foolishness; 'pig-headedness' is perhaps the closets English equivalent (although *bêtise* is a human privilege). Thus, in the specific sense in which I use it does not refer to deficiency, but rather to an intrinsic potential within reason. It manifests when reason, anchored in its evidence base and in logical, scientific procedures, gains a mineral and monumental confidence…It is an excessive, active, confident, determined—unshakable—deployment of reason; it is, in other words, a form of *deraison* (unreason) that is not only a lack but an extension of reason, as suggested by the French language, where the prefix de- can refer, ambiguously, to both deficiency and enhancement. (ibid)

The point I glean from Lachenal is not that that antidote to *bêtise* is to be "more" "reasonable." Maybe it is the very substance of global health "reason" today that leads to the "assertive" and "calculated" pointlessness evident in so many global health programs in Kono. Rather, *bêtise*

centers the role of the mediocre and the banal in intellectually constituting a global health regime, even one implemented with great certainty. Or more to the point here, the actual regimes of global health are often implemented today by young, MPH-graduates who are earnestly driven by the two-year public health curricula that have defined a set of priorities—or at least jargon (*data-driven, behavior change, training cascade, youth empowerment)*— for implementation.[29] Many of the expatriate "experts" and managers never encountered theories of structural violence, let alone the neoliberal justifications for the Washington Consensus; many do not seem particularly curious about Sierra Leone or histories of global health, and, though well intentioned, are themselves constrained by the bounds of the perspectives and models of engagement to which they have been exposed.

The Global Health Class

Even if the NGO programs under the direction of "calculatedly-foolish" expatriate mangers do not often deliver life-altering services to people in Kono, the economy of humanitarian aid is one of the primary sources of livelihoods and survival today. In fact, the serial surges of humanitarian resources that accompany health crises, in some ways, are more dependable given the cyclical nature of these crises in Sierra Leone than nearly any other economy in the district.

[29] Kwame Nkrumah also brought attention to the intellectual mediocrity of the expatriate class: "Members of the European working class live as bourgeoisie in the colonies. They own cars, have servants, their women do not enter the kitchen, and their class origin is only apparent to their own people" (Nkrumah 2011). Historian Peter Kup wrote that the British expatriate technocrats brought in to govern the colonies as relations with the Krios deteriorated were "often uncultured, obstinately suburban, negrophobic, they created their own world and lived determinedly in it" (Kup 1975:191). Both renderings ring rather true to my experience with the insular, white, Freetown expatriate development community. Many of the expatriate development workers that I have met have very little professional experience or any discernable technical skills but are given enormous amounts of power as advisors to the Ministry of Health and whole teams of Sierra Leonean NGO workers. There is a whole infrastructure within Freetown for luxurious, expatriate living sheltered from the chaos and poverty of the city, and many expatriates also travel to the beach every weekend.

Over the decades, people in Sierra Leone have become astutely attuned to the evolving buzzwords of global public health, adapting their scripts and pitches alongside the donor preference-du-jour: small "civil society" organizations jockey for contracts for behavior change workshops and one-off educational programs in schools from the big aid agencies, and young men and women in Kono drift between salaried positions, contract work and workshops that offer just per diems, punctuated by long periods of unemployment. Much of the actual work of designing and implementing programs is performed by well-educated Sierra Leoneans working in the district-level offices of NGOs,[30] not expatriates in central or international offices.

Alongside the "Republic of NGOs" there has emerged something of a *global health class* of people that drifts between being the enactors of this "Republic" and the targets of aid programs. The amputees, for instance, both appealed to their disabilities and impoverishment in requests for food aid from WorldVision and other major NGOs, but also organized themselves into active advocacy organizations that could produce proposals for income-generating activities and, they hoped, receive funding from large NGOs. At least once a day when I am in Kono, a young man or woman who I am speaking to—a motorbike rider, someone drinking coffee in the same stall as me, a friend of a friend, even a nurse at the hospital or clinic, for instance—will ask to show me the project proposals they have in their bags, so that I might be able to send my "sponsors," "people" or "the donors overseas." Many of these proposals reference the writer of the proposal (as both program *designer* and *subject*) through categories legible to the humanitarian economy: *vulnerable, disempowered youth, rural poor, disabled,* etc.

[30] These programs are often called just "projects" by Sierra Leonean NGO workers to reference the fleeting temporality and the fact that once the work wraps up they will likely be out of a job again. Many of those in Kono who are of this cadre of NGO worker do not seem to hold onto any pretense of dramatically transforming the conditions of life in Kono (as opposed to the consultants and expatriate NGO workers, who often do.)

Those same people who present project proposals one minute will often point out astutely the fallibilities of NGO projects the next. In my early interactions with the leaders of the war-wounded and amputee associations, for instance, they insisted upon their ideas for organizing counseling programs and discussion sessions to learn how to better "forgive and forget," a genre of post-war humanitarian psychiatric intervention I had observed in Kono which often seemed patronizing and to efface the amputees' ongoing abject impoverishment. But in another, they would emphasize that they were desperately poor and every day worried about securing food for their families and would much prefer rice in order to "stop thinking so much" about how their lives had unraveled. There is a kind of unsettled relationship that many I speak with in Kono have towards this regime of global health: members of the "global health class" adamantly endorse the logics of the funders as a livelihood practice, but often, like Elizabeth walking past that unused water system without seeing it, maintain a rather distant investment the possibilities for NGOs to alter their health, economic wellbeing or life-chances.

But I always wonder: as people in Kono over the last twenty years have seen thousands of these signboards pop up out of the ground, and see fellow Kono painting the signboards, and arranging the speaker sets for the jingles, and signing the project proposal that will be sent off to Freetown and then Germany, and the region's Paramount Chief and the Mayor stake their claim for legitimacy off of a new partnership with an international NGO that, after an elaborate "launching" or maybe some months of implementation will fizzle, leaving workers unemployed and the "targets" to make do—as much of a social world becomes engaged in this peculiar economy and labor of illusory global health, what does *this* do to peoples' relations to each other and to the notions of care across epistemologies and systems of healing? In some ways this is just the economy of the region, the work that people do in order to forge survivals and

livelihoods. But how does this saturating order of performance ripple out from the narrowly-defined field of global health and into other domains of social life? This is my focus in the next chapter.

Chapter 2: Supervising Life

In a cramped yellow room, healers, herbalists, witch doctors and birth attendants lining the walls, Chairman Sahr Hassan Bangura dumped hundreds pages of documents on the wooden conference table. [31] "I am running the District under the auspices of the Sierra Leone Traditional Healers' Union, approved by the Parliament *for herbs*," he told me in slurred, stilted speech. "It's very strange and surprising to hear that herbalists have medicine for HIV. I know you are thinking it over critically. But we have it. If you want proof we can do it, take it to the lab and make whatever testification."

Chairman Bangura picked one up marked with the letterhead of the Sierra Leone Police headquarters in Freetown, dated 15th April 2012. The Inspector General of Police was writing, it said, to inform all officers in the country that the Sierra Leone Traditional Healers' Union would be carrying out anti-witchcraft activities "in line with the Fangay [witch gun] and Sorcery Acts." The Inspector General noted that the healers had been "advised to respect fundamental Human Right of Citizens and not to take undue advantage of innocent people except where there is an exhibit or evidence to do so." The police, for their part, were also instructed to assist the healers as necessary. The Chairman looked up and made eye contact with me: "So, we have aims and objectives as I wanted to explain, but first, let me go through the documents. Because as a *research* somebody, you have to *search* through everything."

Bangura shuffled through the papers on the table and pulled out two more. The first was the cover page of the Union's constitution. It was starred, underlined, checked and marked as if it

[31] Much of the ethnography and some of the analysis in this chapter was first presented in my undergraduate thesis. However, I put it in conversation with new ethnographic materials and theoretical orientations.

had been closely read and annotated. Among the "Aims and Objective of the Sierra Leone Indigenous Traditional Healers' Union" were: "To reduce the untimely death rate on Sierra Leoneans;" "To bring all stubborn and dangerous healers on board"; "Disarmament of bad herbal missile and witch craft in society;" and "reintegration of witch craft captives after confession."

Finally, the Chairman passed me a letter written to the Eastern Region Union Chairman from the Chief of Njagbema village in Kenema District. It was riddled with typos, and had a thumb printed signature. The letter was a "Request for Favour to Help Screen Our Town from Evil Acts and Witch Guns," since the "people of the above address… have lived in an unwanted, denounced, outdated and barbaric situation, which have cost them greatly and a cause for concern." The request went on: "Njagbema town which was a bread basket of glory, a role model for peaceful activities has now gained the opposite." It concluded with a plea for "aid and rescue" to expose the "evildoers" responsible for the witchcraft and witch guns.
The Chairman watched my face as I read. "Indeed, we are collaborating with the police, this is our certification."

In July 2012, I found myself at the Jabba Street Office of the Sierra Leone Indigenous Traditional Healer's Union, trying to figure out what exactly this organization represented. I was in Kono studying a new NGO project that sought to hire and train "former" "Traditional Healers" and "Birth Attendants" to convince pregnant women and their children to go to public clinics. A couple years beforehand, the government had announced that all healthcare services would be free at public clinics and hospitals for these two groups of vulnerable patients. But in Kono, I was told, pregnant women and children were still avoiding clinics, opting for what people called the "native" side. The NGO had hired thirty of these "traditionals" full-time as healthworkers, equipped them with picture-based manuals on how women should eat, live and

seek care while pregnant, and instructed these former healers to personally accompany patients to the clinic whenever they were ill. After a one-week training session, during which various nurses and doctors had spoken about the importance of coming to clinics early and pointing at simple picture-book drawings of healthy foods to eat and warning signs of serious illness, all of the former traditional healers had been quick to condemn their former work. “We have no need for traditional medicine now,” one woman said. Others adamantly used the word “stubborn” to describe patients who might still seek herbal medicine, but who, after some convincing, would always go to clinics.

I had become so used to their rote condemnations of their own former practices that it was somewhat jarring to hear Chairman Bangura so proudly declare the magical chops of the healers under his Union. “When somebody's foot swells…[we can] take some things from the stomach so the swelling can come down...in fact, we have eye specialists here,” he continued. “Do you know this? Yes! Yes, if you come through the office, we can give you people who you can go and walk with and see for yourself.” But his pressured braggadocio was also somewhat perplexing; when I found him and his colleagues hard at work at the Union, there were no patients in that room. There were only healers, big ideas for what the Union could become, and a whole lot of paperwork.

In this chapter, drawing on research from 2012 and 2021, I explore the relationships between healers, patients and NGOs in Kono District’s contemporary political economy of global health. I review various framings of Sierra Leone’s maternal and child health “crisis” in which women’s use of healers and birth attendants is always a central focus. But who these healers are, what they believe and what they actually offer patients remains ambiguous in this

place so saturated with discourse and health outreach interventions that seek to alternately condemn, harness, hire and put out of work "native" medicine.

The Sierra Leone Indigenous Traditional Healer's Union is an interesting case-in-point: this Union garners its visibility, in part, because "native" practitioners are constantly the focus of health promotion programs. But the Union's own aspirations, as articulated by Bangura and others, reflect not indigenous knowledge nor investment in "traditional" epistemologies of care, but rather evolving priorities for bureaucratizing health systems within global health policy and practice. In exploring how these healers are formalizing their efforts so that they may be "harmonized" alongside other global health actors all engaged in the biopolitical project of, to borrow from Chairman Bangura, *"supervising life,"* something can be learned about how global health as a biopolitical regime arranges its logics, objects and priorities today. Likewise, in studying the evolving frameworks produced by the World Health Organization to harness plural healthcare systems in the service of neoliberal public health, something can be learned about how patients and healers on the ground in Kono now envision practices of care.

Throughout this chapter, I explore the effects of interventions that attribute Sierra Leone's poor health indicators to rural peoples' use of so-called "traditional medicine." Attuned to structures of mimesis, commodified notions of indigeneity and traditionalism, I encounter a range of characters who complicate any clear sense of what it means *to be a healer* in Kono today. Plural landscapes of health and care are now saturated with the immaterial discourse and imaginaries of neoliberal global health policy, obfuscating the actual possibilities for care. I end, then, by following one patient's desperate search for healing across different sites of care, punctuated more by urgency and pain than any investment in a particular episteme—or imaginary—of care.

A Startling Admission

One early morning, I walked with Peter, one of the former traditional healers turned community healthworkers, up a long, rocky hill to a village only accessible by foot and motorbike. Midst the morning drizzle, we were met by some forty faces peering at us from the veranda of a hut. “We thank you, thank you, thank you, *thank you*,” the village’s chief said, handing me a chicken and a stalk of bananas. Despite my attempts to articulate that I was just studying the project, everyone around clearly looked at me as benefactor. Women lined up to repeat what Peter had taught them on his morning rounds: wash your hands after using the toilet; use a condom to prevent HIV; if a child seems ill, do not go to a drug-peddler or herbalist, but go the clinic *where you will receive free care*. The women had been told that they were guaranteed free care some two years back through the Government’s Free Healthcare Initiative, a spectacularly announced and lauded plan to increase women’s uptake of clinical services that was quickly followed by stock-outs of drugs and, nurses in Kono told me, plummeting clinic attendance-rates. The women in the village told me that until Peter had begun monitoring and accompanying them to the nearby clinic, they had not gone often. But at the same time, they explained, like so many other clinics, this one often had no drugs, and when they went the nurse would check them but not have anything to give them except a prescription written on a piece of paper to bring to a pharmacy to buy. Their patience with the clinic would run out if the drugs in the clinic continued being unavailable. Still, they said (and this I did not fully understand): Peter’s mere presence and accompaniment as a hired community healthworker had made all the difference, even if the clinic remained stocked-out of supplies.

Later in the week, I accompanied another community health worker (and former birth attendant) named Finda to another village three miles from the clinic. We had a similar meeting with the *bɛlɛ umandem* [pregnant women] who had been newly enrolled in the project there, and I heard similar praise for the project. At the end, however, a young woman stood up awkwardly in the back of the crowd and began to yell. "I walk, walk, walk there and they might not have medicine for the delivery. It's days off of my farm. They don't treat me well. Maybe I'd rather the baby die, and I just try again." Everyone seemed startled—not just the community health worker, but also the audience of ordinary women from this village—like this particular young women had let a secret slip out.

Child Deaths, Maternal Loss, Regimes of Intervention

I too was unsettled the words: "I'd *rather* the baby die," and the sense of banality to infant death that they evoked. Intellectually, I knew that infant death in Sierra Leone was a quotidian feature of life. Approximately one in five children die before the age of five in Sierra Leone (World Bank 2011). Doctors at the Koidu Government Hospital—perhaps prone to amplifying the catastrophic conditions in which they find themselves working—told me that in the thick of the rainy season when the malaria transmission was most widespread, up to half of all infants died before their first birthdays (see also Hardin 1993:35). But the woman's comment beckoned a frank ethnographic engagement with how the ongoing precarity of child health in this region is woven throughout the fabric of maternal and familial relations.

While women like the one I encountered with Finda frequently made reference to the loss of their infants and their fears of their children falling ill, none of those I met described a sense of

risk to their own lives of giving birth. Part of this certainly was due to issues of access, my own position as a man, and the particular economies of discourse that have serially coalesced on the country surrounding infant death. But the maternal health situation in Sierra Leone has also been muddled by tautological claims and expert certainties surrounding maternal deaths enfolded into recent humanitarian interventions. A line constantly cited in NGO meetings, donor presentations and healthworker workshops in the country is that Sierra Leone is "the most dangerous country in the world to be a pregnant woman." Many NGOs reference the statistic that "1 in 8 women die during childbirth" (Amnesty International 2009b; Moszynski 2009), though I have never found the original sources of this number. World Bank indicators suggest that the actual maternal mortality ratio is closer to 890 per 100,000 live births, which, when multiplied by the average fertility rate in the country is closer to a 1 in 20 lifetime risk of dying during childbirth (World Bank 2011)—still one of the highest in the world, but nowhere near as common a cause of death as infectious diseases and other health issues.[32]

Within Sierra Leone, the donors and NGO bureaucrats making decisions about programmatic budgets, negotiating with Ministry of Health officials and writing reports to be distributed to funders often fixated on one notion of causality for maternal deaths: rural women's

[32] It is also important to keep in mind, as physician-anthropologist Claire Wendland has shown, that even official WHO maternal mortality models are based on estimates that adjust the mortality rate for such distal parameters as GDP per capita[32] and rates of skilled attendance at birth (Wendland 2016). The model used to ascertain official WHO maternal mortality rates does not include a single empirical "count" of maternal deaths. Rather it is made up of conjecture derived from other economic and health indicators (67). When actual counts are conducted, different stories may emerge. In 2012, I observed a three-day sisterhood study across three villages in Kono which hundreds of women were interviewed about whether any of their sisters had died in childbirth. This is a standard method of estimating rates of maternal deaths in countries without functioning vital registration systems. The results of such studies are arbitrarily increased in the WHO model by 10% to "compensate for the underreporting that happens due to secrecy or obliviousness about abortion-related and other early pregnancy deaths" (67).[32] In the study that I witnessed, only two women out of the many hundreds discussed were reported to have died in childbirth. And certainly, how one defines a "maternal death"—any death within a month of giving birth? A year? What about slow deaths from botched deliveries or ostracization from obstetric fistulas?—comes to shape how one quantifies the scale of the maternal mortality problem in a country.

insistence on delivering at home rather than in clinics. Most of these births, the explanation went, were attended by what are referred to as Traditional Birth Attendants (TBA). These women, unable to treat complex cases and often unable to stop hemorrhaging, were also reportedly present at most maternal deaths. While there has never been a conclusive study showing that rates of skilled birth attendance are actually correlated with reduced maternal mortality—particularly in a place like Sierra Leone, where merely giving birth in a poorly equipped and understaffed clinic may not do much to improve women's chance at survival—the assumption that the grave inequities in maternal mortality rates are due in large part to the skill-levels of birth attendants is often taken as common sense within global maternal health programs (Wendland 2016:69).[33]

As various NGOs and government workers have come into villages attempting to train, condemn, incorporate or equip TBAs (in addition to male "traditional healers"), what exactly makes up that title, what the "tradition" is to which it refers, has become increasingly blurred. Most women in Kono know the TBAs as healthcare practitioners who provide care at home deliveries and are increasingly used to help out within clinics (particularly those staffed by male nurses who are sheepish about assisting in *"uman biznɛs"* like uncomplicated deliveries), rather than explicitly providers of age-old medicinal practices. Sometimes, they are even called

[33] A great deal of public health research and literature has explored the efficacy of training Traditional Birth Attendants (often referenced as a universal cadre of health providers, across cultures and geographies) in basic obstetric techniques, such as distinguishing emergent from non-emergent cases and setting up referral systems for complex home-deliveries to be referred for more advanced treatment (Bergström and Goodburn 2000; Sibley, Sipe, and Koblinsky 2004; Sibley et al. 2012). Even in Kono, many of the so-called TBAs I met reported being trained by WorldVision, UNICEF and the Sierra Leone Ministry of Health. In fact, when I tried to collect life stories of some those who called themselves TBAs, many said they that they had learned to be TBAs from a UNICEF nurse and denied being taught by another TBA or relative. These women are indeed the least equipped, but most local resource for delivering babies and often had little if anything to do with "traditional" birthing practices. But most are now attached to government health posts with different degrees of formality. In other words, TBAs are in many ways the product of the very public health regimes that now claims to harness their "local" and "indigenous" knowledge of maternal life and desires, even while condemning it.

"unqualified nurses." But even though TBAs now often resemble more auxiliary clinical healthworkers than non-compliant midwives, every clinic in the country is covered in posters mandating that women come to clinics for prenatal care and deliveries. Town and Paramount Chiefs, at the behest of NGOs and the Ministry of Health, announce major fines for home deliveries, though I have never heard of one being enforced. Healthworkers—expatriate and Sierra Leonean—talk incessantly in the hospitals about the lack of sense in women's continued use of these local midwives and healers. "We have to figure out what these traditional people are *doing* out there, charging so much money and with their patients dropping *like flies!"* one Sierra Leonean-American nurse, recently returned to the country to manage a public hospital nursing program with an NGO. In 2018, in a very rural village, when I asked a group of TBAs about home deliveries, one curtly responded: "Everyone who comes, every stranger who comes, tells us that it's wrong to deliver at home. So we have nothing to say about that."

Traditional Birth Attendants very well may endanger women with their lack of medical training, but the actual structural impediments to usable obstetrics—challenges that endure even with supposedly progressive policies like the Sierra Leone Free Healthcare Initiative—remain unaddressed and unnamed. But these real-world implications of this structural impoverishment are very well known to pregnant women and new mothers living in rural Kono. Most clinics' birthing rooms in Kono are filthy, with rusted, broken equipment; nurses are sent to manage them with little supervision, experience or equipment, and may spend long periods away from the facility. Drugs are in short supply, and ambulances can take hours, if not days, to reach clinics to retrieve women in protracted labor or other emergencies. The situation at central hospitals can be even worse.

This focus within recent regimes of global health on women's use of TBAs' does more than just efface the structural barriers to care. It has prompted an explosion of training and outreach programs that, like Ichende's own community healthworker program, constantly highlight the risk to babies, children and mothers of not attending clinics. "Embedded in [such] intervention through training, then, is the idea that rural women must be taught to feel," anthropologist Sarah Pinto writes of a range of similar programs in Utter Pradesh. This is not articulated directly: Finda, the community healthworker I was following, did not explicitly tell her patients that they should *feel* more attached to their own kin and thus bring their children to clinics when ill, or to their own bodies and lives and thus must deliver in obstetrics rooms. But the framings of the maternal and child health situation in these programs entrench a moral economy in which rural Kono women are frequently referenced by healthworkers, local political leaders and NGO managers as irrational, primitive and indifferent in the face of death. One village chief, for instance, once responded to my questions about the rates of home deliveries in his village by telling me: "I am very sorry to tell you that over 65 percent of Sierra Leone is illiterate. *And I think you know what I mean when I say illiterate.*" These regimes impart a sense that the impoverished, cultural subjects of maternal and child health interventions must be taught a new rationality of care, centered around the primacy and inviolability of life to which they ought, as normative human patient-subjects, be attached. "With [that] rationality," Pinto continues, "comes affect" (Pinto 2008:367).

Traditional Birth Attendants are not Traditional Healers. The causes of child mortality (malaria, diarrhea, pneumonia) are not the same as the causes of maternal deaths (hemorrhage, sepsis) —they require different technologies, drugs and cadres of healthworkers. And the rates, and thus presence of, maternal deaths are not the same as child deaths in rural Kono. But in

Sierra Leone, the two crises seem in NGO and global health discourse to blend into one, often because they are portrayed as revolving around the same issue: the lack of uptake of lifesaving services. Women should *want* to want to live, should *want* their children to live. Why do they continue to risk their lives and those of their children, and as a tradeoff for what? Lack of access to healthcare services, dwindling drug supplies and over-taxed nurses are alluded to as concerns, but often only secondarily. The priority in these programs is almost always, implicitly, to teach women that they should *want* to live.

***Mami Wata,* Mimesis, A Sacrifice**

As I continued to shadow the former-healers-turned-community healthowrkers on their rounds, one male community healthworker named Mohamed was particularly eager to tell me about his work and wares. Mohamed always wore a spacey smile and seemed to conjure both humor and condescending derision among the other healthworkers and organization's staff. He was called "Dr. Bongoo" by his colleagues, a comical name, because he wore a large-brimmed hat in the market with his powders and herbs set up on a blanket in front of him. Mohamed was apparently a popular healer, and I had been told that he had recently been reprimanded for continuing to sell his medications door to door on his community healthworker route. I continued to run into him in the streets, and each time, though he carried in his backpack the community healthworker materials he had been provided, he brought up the possibility of us collaborating to sell his powders. "You know, we can work together." Together, he said, we could expand production; in such an over-saturated market of herbalists, he seemed to say, my investment as an American

could afford it legitimacy and an edge against his competitors. “You, me—you [can] bring machines from America!”

Once, as I sat at the central coffee stall and betting parlor in town, Mohamed appeared, as he often did, with his wares on his back and sat down next to me. A man in rags, one of the few men who sleep on the streets of Koidu tormented by voices had just walked by the stall, babbling to himself. The other men in the stall yelled out commands to the mad man (“*A wan lɛ yu wok lɛk soja man*! *Brɔsh di tit dɛm! [Walk as a soldier! Brush your teeth!]*”) and burst into laughter as what they called “the madman” earnestly and furiously obeyed. I asked those around me what they thought had caused this condition, and while some said the madman was haunted by the spirits of those he had killed during the war, others insisted his condition was caused by the bush devils. This is the *Krio* term for a local spirit, one that can be helpful, trickster-like or fatally dangerous. (The term “devil” has no overlap with “Satan”—though Pentecostals condemn interacting with either—and likely emerged from colonial missionaries decrying all local deities as “devils.”)

Mohamed joined the conversation and began to describe his own relationship with a devil—one that gave him his powers as a healer. “Now this devil, sometimes it tells you 'marry me,'” he said. “It is a woman. If you are man, it is woman, if you are woman, it is man. Like me, she tells me: ‘Marry me.’”

Someone else jumped in to elaborate:

> Do you know what this man is trying to say? He is talking about this devil. There is something in every lineage. It might happen [that] your grandfather has devil. If he passes away, the child of that grandfather will have devil also. For instance, for this man, he had the devil from his grandfather. Now his grandfather gave the devil to him after he died. Now he enjoys [a] connection to the devil…

Early debates in medical anthropology considered the relativity of the normal and pathological, the possibility that a shaman in one culture could be labelled a schizophrenic in another—and vice versa (see, e.g. Benedict 1934). Here things were not so clear. The man on the street was tormented by his devil, while Mohamed had married his own and staked a career as an herbalist whose skill derived precisely from this marriage. But there was an element of theatrics in Mohamed's story and the way the others in the shop jumped in to complete Mohamed's biography as if it were a familiar folktale. Mohamed seemed to have so embraced his character as an enchanted, eccentric healer that he inspired curiosity from the others in the café, but perhaps also comic relief.

"Yeah, so me, I went under the water…The devil I have a connection with, she gave me two children," he said, counting off on his fingers.

> But she has already taken them back from me. Sometimes, when the devil was operating with me, she used to travel at night. You ordinary individuals have to pass across [sleep through] the night. I am not a normal somebody—I am working with the devil. But now, I am no longer working with the devil, so you see me now. The children are with the devil. You cannot see them now, only when you connect with her…
>
> I traveled underwater…she has a fine house. She showed me money, she showed me gold, she showed me diamonds, we were married, there she showed me Leones. It was a perfect house, existing under the sea. Conditions that can never exist in the world. The internet, food to eat.
>
> But now, I have no connection with the devil—so everything is missing.

Someone asked why he had cut off his relationship with the woman, and Mohamed said it was a matter of sacrifice. "Sometimes, when you are married, you can need something to offer. Blood, or it might be a human being." But Mohamed was not interested in performing such a sacrifice. "So because of this, I disagreed with the offer from the devil."

"What did the devil ask from you?" I asked.

"She asked for sheep. "

"Why didn't you offer the sheep?"

"I don't have money for sheep."

Mohamed's enchanted persona was rooted in his gift of moving back and forth between worlds—or at least speaking of such traversals. But this gift was also fraught with the basest of material concerns of the mundane world: his poverty, his inability to offer the devil a gift, the violence that such impoverishment can beget (even if, for now, Mohamed had declined the suggestion to sacrifice a human).

I asked: "Can you still do your healing without devil?"

"No, no, I can never fully heal someone without the devil. She has taken the talent away from me. Only God can help." His was a world, he seemed to say, that was so poor that his magic no longer even worked. And so now he was a global health NGO's community healthworker.

Mohamed described a devil similar to a *mami wata* spirit, a West African and Caribbean mermaid figure known for being a trickster and healer. In Kono, *mami wata* is often referenced as akin to a character in folktales, one that may-or-may-not exist but that should still be approached with caution. She is typically portrayed as a foreigner. The cult surrounding the spirit is thought to have possibly originated from an 1880s photograph of a Samoan snake charmer who performed with a German "Peoples Show." A 1901 photograph from the Niger River delta shows a shrine to a masquerade that is "unquestionably based on the snake charmer print" (Drewal 1988:170). Somehow, the print had reached West Africa on a European ship where it inspired the imaginations of colonial subjects across West Africa and the New World, just as it

had German audience members captivated by the circus show. Since then, images, shrines to and mediums of *mami wata* have always included symbols of foreignness, modernity and oriental mysticism: mirrors, sunglasses, coke-cans and headlights frequently adorn statues of the spirit. "Like anthropologists, Mami Wata devotees 'study' others—overseas visitors—and generalize them from impressions, experiences, and other evidence," writes one *mami wata* iconography expert (Drewal 1988:160). I was not sure if Mohamed was a devotee, but in describing his sexual relations with a *mami wata*–like figure, he did provide an entrypoint into his imaginings of an other-world of riches: enough food to eat, internet and fine houses, "*conditions that can never exist in the world.*"

Mami wata not only reflects *African's* images of an esoteric Other, but is layered with Euro-American imaginaries of the esoteric, the exotic and the oriental (extending from the 19th century to Western imaginaries of exotic African esoteric ritual today). Likewise, as Mohamed told me the story of his relationship to *mami wata*, it seemed perhaps another part of a somewhat loopy persona that was split, curated and kitschy. His investment in this epistemology of the occult and that which it signified was ambiguous underneath the commoditized, choreographed mimesis.

Mohamed had not stayed with the *mami wata*, and now asked for machines from America. He required a new means of distinguishing his medicine from others', since he no longer had the advice of his spirit. But Mohamed was also working as a maternal and child health community healthworker. Mohamed was less literate than some other healthworkers, less deft at replicating the rhetoric about abandoning traditional healing and birth attendants. When I shadowed him around town, he pulled a heavy scale out of his "health worker bag" and told his patients to step on it but was unable to read the number or tell me what he would do with it, as if

the scale was another enchanting technological device derived from the *mami wata* world. Mohamed was the only community health worker who did not emphatically tell me that he had completely abandoned all herbal medicine work now that the project had started. And yet, it was possible that the others in the program (along with their clinic-avoidant patients) were also intricately connected to this nocturnal sphere of *mami watas*, and, like the bush devils that inspired their knowledge of esoteric remedies, transformed each morning into something else entirely: NGO community healthworkers heading out on rounds.

The Union

For several weeks, Mohamed had told me that he wished I would attend a meeting of his healer colleagues, a group with who he clearly spent much more time than with the NGO's healthworkers. I could not quite figure out what he was referencing—it sounded like a bunch of herbalists got together to socialize, "discuss" and regulate their wares. But I was eager to meet healers who continued to practice out of the orbit of the NGOs' condemnation, and arranged to attend one of the weekly meetings of the Sierra Leone Indigenous Traditional Healer's Union with Mohamed.

Mohamed showed me down the road adjacent to a lush swamp in the shadows of the Koidu Holdings mine. The first day I arrived, the Secretary General was out, but another officer offered to show us around. There was hut with beds on the ground, and a concrete building with what looked like a conference room with a splintery long table that exceeded the size of the room by so much one could barely walk around it. There was also a garden where the Officer said they grew herbs for their remedies.

As I got ready to leave, I noticed, near a smoldering fire in the back, a girl laying on a bench, gasping for breath. Her face was swollen to the same size as her torso, her cheeks bulging with growths under her skin and one eyeball protruding out of the socket from the pressure. Her mouth had been stuffed with gauze that had turned brown after absorbing what looked like blood and pus leaking from her gums, and her cheeks were coated with dried green powder and leaves. "She's getting better," the Secretary said, handling her head gruffly and pressing on her cheek. "See, it's gone down." The girl sat up; she was no more than thirteen or fourteen, and looked around, confused. I could not believe how painful this condition looked, and had never seen anything like it before, but the Secretary quickly ushered me away, and told me to come back the next day.

We arrived the next day to a much larger crowd in the yard. There, I met the Secretary General, an old man with bright yellow eyes, drooping eyelids and the smell of *omoli* liquor on his breath. He spoke in flowery but slurred English, and when I mentioned the NGOs' current "collaboration" with healers he nodded thoughtfully. "Yes, we have waited for this for…for a very long time. You know the dismal health statistics in Sierra Leone. We know them too. All healers—native doctors, herbalists, nurses, doctors—we are all in the same mission: *improving the health status of the people of Sierra Leone."*

Members of the Sierra Leone Indigenous Traditional Healer's Union, he explained, trace the organization back to a 2002 World Health Organizaiton (WHO) report on the roles of Traditional Medicines in health systems strengthening. This report stated that "80% of the population living in rural areas in developing countries depend on traditional medicine for their health care needs," and affirmed that so-called traditional medicine was not a false system of healing alone that should simply be replaced by "Western" biomedicine, but a kind of primary

healthcare itself (World Health Organization 2002: 1). The use of the term "traditional medicine" in such a statistical analysis is somewhat confounding, as if the different epistemological, healing, ritual and religious systems that constitute diverse repertoires of care—here defined as "the total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observations handed down from generation to generation, verbally or in writing"—could be considered a single coherent entity. But the premise of this report was not on identifying "tradition"; it advocated, above all else, for a rather abstract vision for "integrating" traditional "medicine practices and medicines" into public healthcare systems.

In 2002, a Sierra Leonean academic, in collaboration with the Ministry of Health, established the Sierra Leone Traditional Healers Association (SLENTHA) to both recognize and explore the possibilities for this integrating of local practitioners into the country's (and donors') plans for post-war health systems reconstruction. The academic apparently even established an office and herbal pharmacy in the country's main teaching hospital in Freetown. But, almost as a matter of common sense, when the All Peoples Congress government took over following elections in 2008, a splinter group of Traditional Healers broke off and established the Sierra Leone Indigenous Traditional Healers Union (SLITHU). This was the organization that Chairman Bangura now represented, allied with the All Peoples Congress.

Nobody did more to elevate the status of SLITHU than Field Marshall Dr. Alhaji Sulaiman Kabba, a flamboyant and charismatic healer who was soon chosen to take the helm. Dr. Kabba said that he was trained across West Africa in the arts of traditional African medicine. In 2021, I met him in Freetown, and he told me stories of showing up in cities like Ougadougou,

Banjul, and Accra, and having his eyes opened to the legitimacy and ubiquity of magical healers, witch doctors and herbalists across the region. He said he had traveled to India and China for further training. (When I enthusiastically asked where he had been in China he stuttered and could not name the city.) Kabba was particularly influenced by former Gambian President Yaya Jammeh, a strongman (and widely considered a human rights-abusing autocrat) who surrounded himself with powerful occult healers and led spectacular (and apparently deadly) anti-witchcraft campaigns as important spectacles of his regime (Nossiter 2009; Amnesty International 2009a). President Jammeh, who Dr. Kabba had gotten to know personally, properly respected "traditionals" and saw the potential for traditional medicines to be manufactured on mass and sent across the world.

In our conversations, Kabba often returned to this vision of "factories" for herbal medicine, in which Africans would be able to turn crude leaf powders into tablets and market them around the world. In these moments, he suggested that the "traditional" pharmacopeia was analogous to that of Western medicine—it could be reduced to its chemical constituents, studied with labs, scaled up, marketed, respected, and in the process, a vision for pan-African, home-grown industrialization advanced. But perhaps what Dr. Kabba most learned from President Yaya Jammeh, and where his passion truly lay, was in the possibility for magical healers and witch doctors to buttress postcolonial African political authority and in so doing advance developmentalist political agendas. Dr. Kabba foresaw the postcolonial West African state to *align* with healers and for this alignment to promote economic development. This is not a simple task, because, as the Gikuyu writer Ngũgĩ wa Thiong'o (2007) elucidates in his satirical novel *The Wizard of the Crow*, while postcolonial African political leaders' often surround themselves with magical practitioners to bolster the internal authority of the ruling party (by inspiring awe

and reverence among constituents), such proximity may also alienate the donor communities on which many African governments rely. In the case of the *Wizard of the Crow,* the Ruler resorted to the logics of bureaucratization espoused by the Western consultants flown by the IMF (and also conveyed in the WHO Traditional Medicine Strategy cited above.)

> The Ruler issued a special decree that traditional African healers would no longer be called sorcerers, diviners, or witch doctors. Henceforth they would be called specialists in African psychiatry, in short, afrochiatrists, and they would be allowed to call themselves *Doctor.*
>
> The Ruler announced that all those who wanted to become the founding doctors of the new academy must present themselves at the State House for a national test. The very best among the founding doctors of the academy would comprise the Ruler's advisory council to advise the Ruler on how best to ensure that people's heads were on straight—behind the Ruler's thought (622).

Field Marshall Dr. Kabba took a different tack, raising the profile of the Union through a series of spectacular launchings and collaborations with the Sierra Leone President himself. Throughout these programs, Dr. Kabba insisted that his primary focus (in partnership with the ruling government's post-war agenda) was to *redirect* the activities of sorcerers in the country from doing evil, harming one another, cursing-to-cause-death, to instead a kind of biopolitics, or, as he said again and again, to *"healing and doing good."* While the entanglement of collective occult anxieties and contemporary postcolonial politics is a common phenomenon across the continent (e.g. Geschiere 1997; Comaroff and Comaroff 1999), Dr. Kabba was a master *bricoleur* and brought his anti-witchcraft campaigns into a whole new discursive terrain. These operations themselves drew on the jargon and ideologies of neoliberal postwar African development. Dr. Kabba claimed to run a *disarmament* program for witches, modeled, it seemed, off the famous Disarmament, Demobilization and Reintegration campaigns operated by the UN

in the wake of the Sierra Leone civil war. Anthropologist Samuel Mark Anderson draws attention to the resonances between Dr. Kabba's work to "rehabilitate witches as productive herbalists" (as reflected in the document Chairman Bangura had shown me in Kono) and the Sierra Leonean Government's post-war "Attitudinal and Behavior Change Secretariat" that was lauded by donor groups attracted to such paradigms for framing post-war social transitions.[34]

Anderson describes Kabba's dance between the imagery of traditional West African culture, the solidification of postcolonial political power, and the demands of technocratic donors as emblematic of a broader politics of what he terms *rebrandcraft* (a politics also embraced by the post-war Sierra Leonean state at the time.) After all, during the war, international media had reported widely on so-called ritual practices driving violent and bizarre behaviors of combatants. The members of the hunting militias that had initially defended villages against rebel troops (and ultimately were formalized as a paramilitary institution and accused of atrocities against civilians) wore ritual tunics which they claimed would make them immune to bullets and bolstered their ruthlessness. Anderson quotes Dr. Sulaiman Kabba as describing "our *rebranding* effort to shift the paradigm complex attitude of some malcontent persons opting to always display wicked knowledge on the innocent," appropriating the language of marketing, developmentalism, but also the almost magical power of tinkering with immaterial discourse in the context of millennial capitalism. "In Kabba's telling," Anderson goes on, "SLITHU's key contribution has been to recuperate Sierra Leone's modern public image"—via, that is, the re-*branding* of practitioners of African magic— "and, thus, international investment" (Anderson 2019).

[34] By the time I arrived in Sierra Leone, the only trace of this Secretariat—if it had ever existed beyond announcements to attract donors—was a dirty "Welcome to Freetown" signboard at the Freetown airport on behalf of the Secretariat.

Squadrons of healers, each with different specialties (identification of witches, witch-arresters, medical support for attacked healers) would infiltrate towns with journalists and police officers in tow exorcising “witch guns” and detaining witches for rehabilitation. Under Kabba’s rule, the Union came to appear as almost the sorcery-regulating arm of the Sierra Leonean State, or at least the ruling party. Kabba boasted of how he had galvanized all the idle youth in the “Upgun” region of Freetown that is notorious for violence and unregulated markets but also dangerous occult activities, to put their efforts to *good*, to healing with herbs and fighting evil—a claim that also signified, as Anderson notes, the extension of state power into insurgent regions of the post-war city. Kabba was also proud of bringing together high-level members of all the Sodalities in Sierra Leone—"secret societies” that have long served as havens for potentially-insurgent activity outside of the domain of state politics and jurisdiction—into the Union, not to expose their secrets but in order to secure their collaboration in this post-war effort at promoting development.

I was never sure what to make of all these claims. Traditional healers are not the same as herbalists which are not the same as sodality-members, though all have resonances in the language and occult authority they conjure. Kabba and his colleagues repeatedly referenced their goal of “bringing *them* all on board” through a formalized institution and set of commitments, but this seemed particularly impossible in the case of the sodalities, male and female esoteric societies that often cut across ethno-linguistic lines but are very different in the different regions of the country. I had seen development agencies in Kono organize workshops to facilitate Chiefs’ developing “bylaws” to regulate initiation rites (the ages and forms of consent for circumcisions, for instance) and supposedly high-ranking members of the *poro* or *sande* societies

would show up to "represent" the society. But longstanding interlocutors would tell me frankly that these often did not translate into anything concrete in the "society bush."

The whole image Kabba painted of eager cooperation seemed antithetical to the political and institutional history of the *poro,* the largest sodality (and the main one in Kono) which has always served as an insurgent and contested political space that regulates more visible forms of political authority (Little 1965; Albrecht 2016). As in the case of the sodality-regulating workshops I had witnessed, Kabba's claims seemed at times to be most closely reflecting a Euro-American imaginary of all the various signifiers and agents of West African "black magic culture," homogenizing a set of actors, institutions and hierarchies in ways that likely had little resonance with the role those institutions played in ordinary people's lives. In fact, over the course of my research and engagement with Kabba, I discovered that other anthropologists had written extensively on him and what his work signified, for his work and claims seemed so innovative in scaffolding the jargon and ideologies of post-war reintegration and tribunals with notions of "deep" Sierra Leonean culture. Kabba had mentioned all the "many many white people and journalists" who had worked with him, but could not remember the anthropologists by name when I brought them up (and who, in some cases, had partially staked dissertations on their relationship with Kabba and his authority). While reviewing the Traditional Healer's Union website, I noticed a paragraph on Kabba's deft skills at "appropriating pervasive marketing rhetoric" that seemed out of place from the rest of the text on his supreme fetish-magic techniques. I discovered that he and his organization had copied a paragraph from an article in Cultural Anthropology (on Kabba's skills at appropriation and mimesis no less) and included it in the hagiographic biography of Kabba presented on the website—a kind of fourth dimensional *bricolage.*

Perhaps imaginaries surrounding healing always emerge from the cross pollination of multiple traditions and epistemes of care. But like *mami wata* devotees, the role of the "healer" (as defined by the Union) seemed particularly born of Bangura and Kabba's "studying others…[and] generaliz[ing]… from impressions, experiences, and other evidence" (Drewal 1988). Sierra Leone is, after all, a place that has a particularly extensive history of being a testing ground for evolving phases of global health development, each of which have brought new models for how to envision "developed" healthcare systems and the forms of expertise needed to get there. These phases also bring resources for those in the "Global Health Class" who effectively reflect donor priorities. The Union's work seemed, in some ways, largely operant at a register of public spectacle, legitimated via international recognition. The Union would never have gotten the visibility it had if its leaders had not tapped into evolving donor imaginaries and ideologies: from anxieties about the ongoing threat of violent "mindsets" among Sierra Leoneans, to the ongoing contestations about the roles of healers and birth attendants in worsening Sierra Leone's health indicators (described above).

Ultimately, Kabba's proximity to the country's political leaders led rivals to accuse him of corruption, as well as some members' frustration at what they called the "politicization" of the Union and thus their work. When the Sierra Leone People's Party (SLPP) took over power in 2018, it was almost a matter of common sense that a new healer aligned with the SLPP patronage networks (and its base in the south of the country) would take the helm of the organization from Kabba. (In fact, the Union would no longer be called "SLITHU," but would return to the name of the Union that had existed during the SLPP government *before* Kabba took over). When I met Dr. Kabba in Freetown and listened to his reminiscences of working alongside the President in the early postwar days, there was an overwhelming sense of his time having passed despite the

verbose auto-hagiography. He showed me photographs of a sign I had seen during the Ebola outbreak featuring his face and declaring that he had stopped his healing work for the sake of preventing Ebola transmission. This seemed to be his last hurrah. In fact, I could not tell at the time if he had had any interest anymore in curing individual patients, nor even had a clientele. All of his stories were of his high-days of administration, politics, organizing. Was he a *leader* of healers, a charismatic and ambitious individual who had cobbled together a story of mystical training and occult power before appropriating the development discourse, or a healer himself?

At the end of an interview at his compound on the outskirts of Freetown, however, I spotted over his shoulder a grated window out of which a hand poked out. In a cell-like room, a naked "*Kres man*" was laughing, chained to a log. "*Na fambul, noto peshɛnt* [That's a family member, not a patient]" Kabba said quickly, having noticed my distraction. "*Wit Korona, wi nɔ de trit dɛm. Wi de wit di gɔvment*. [That's just a family member, not a patient. With Corona, we don't treat anymore. We're with the Government regulations.]"

Specialization

On the ground in Kono the district-level leadership of the Sierra Leone Indigenous Traditional Healer's Union, under Chairman Bangura, had different priorities. Like Dr. Kabba, Chairman Bangura was pursuing an ambitious vision for healers far beyond the bounds of patient care, but he was less concerned with grand overhauls of the brands and "mindsets" of the country's

sorcerers, and more motivated by a vision of bureaucratizing healers to bolster the health system of the country. This bureaucracy would be premised on notions of specialization. When I met him around the conference table at the Kono District Union office in 2012, he told me:

> We have people to prevent patients from evilness. Or that fetishization. Or that witchcraft. Now we have people who are sick, when you are sick, we find means and ways to know what is your sick. Getting to know your sick, we have the people who exactly can bring medicines. To your aid, to medicate you.
>
> Like, if it is malaria, this man is purely for malaria. If it is for feverishness, this man is purely for feverishness. If you are getting crazy, this man is purely for crazy people. In fact, you sometimes have herbalists at the hospital there. Because the people practicing there, when they go to the computer or whatever testing machine, they may not see the sick. It is because of evil. It is because of evil spirit. It is because of evil fetish practice. So you will never see. If you look in the microscope, you won't see nothing!

Bangura showed me certificates, photographs of approved healers, loose pages of their constitution, thank you notes from political figures. He had clearly been waiting, preparing, for something akin to auditor to arrive to display all this bureaucracy in paperwork form—as if all this was born of an extreme adherence to culture of financial scrutiny, skepticism, audit, and inspecting qualifications that was advanced by public health funders and management-oriented global health practitioners. "We never allow somebody to practice as a traditional healer if you don't have any documents!" he said. He said that they had an examination procedure that would ascertain a healer's skills and specialty.

> We ask your specialization, and when you tell us your specialization, then from there we test you, and see how you best work alone in your way. If we find out that this work that you have done goes successfully then we document you. But we can't just document somebody because they say 'I am an herbalist!' What kind of herbalist are you? What can you do? What is your specialization, you tell us! When we get to specialization, then we can identify what type of native doctor you belong to.

Bangura said that there were many types of practitioners under his domain: witch doctors, herbalists, magicians and fortunetellers, Traditional Birth Attendants, mental health specialists and ceremonial dancers, but "all are traditional." The bureaucracy he claimed to run reflected a vision of a functioning and well-managed healthcare system: a centralized overseeing body; a licensure and specialization process; a headquarters with patient records; a malpractice system. The specialization and the credentialing also enabled a fluid referral system and thus a facilitated means of collaboration among healthcare providers. "I can give you somebody who is a witch doctor," he said, if that is what is needed, "who can tell you precisely what concerns about witches, and then how to track them and how to get them and how to get rid of them. I will identify somebody who can only deal purely with leaves." The Kono Union's greatest ambition, he said, was an herbalist hospital, with different departments, a lab to study their leaves and treatments, and an auxiliary staff to nurse and care for inpatient witchcraft patients.

Bangura once showed me received a request from a Chief for witch-cleansing services. It had been submitted as an official, printed application. I thought of all the steps required: translating it from *Kono* to *Krio*, scribbling it on a slate and then on a piece of paper, driving it to Makeni or Freetown to access the only computers and printers available in the area, printing out a document riddled with typos, then bringing it in a minibus back to the village for the chief to apply his thumb print because he could not write his signature, before finally returning with it to Kono. Bangura did not mention if the Union had actually provided the services after the request was properly received—it was the formality of the document he wanted me to see, to vindicate his governance and the professionalism of the Union.

To what end was all this work in Kono being done? Dr. Kabba's intended audience was more evident: a Sierra Leonean citizenry tense with occult anxieties and fears of resurging social

unrest after the war, and donor agencies looking to Sierra Leonean leadership to oversee a postwar transition of disarmament and reintegration Bangura's bureaucraft had less clear effects. I knew from speaking with interlocutors in Kono who sought care from local healers that they often selected healers based off of reputation or proximity, and I had never heard of anyone asking to inspect a healer's license to practice.

Perhaps Bangura's efforts may have been to position the Union as a legitimate actor in the local humanitarian political economy, one that might be able to tap into the serial flows of global health resources and funding through its auditability and alignment with a WHO vision for health systems integration. But evidently, the Union's work was not all directed at an imagined transnational audience of funders and WHO technocrats. In the document Bangura had shown me, that Chief had been instructed to formally apply for the witch-cleansing services before the cleansing could be considered. The broad logics of audit and bureacraft had come to inform how individuals in the Union engaged with other individuals seeking their services.

Dreaming of Alma Ata

"All this began—back in the 70s!" one of Bangura's successors once told me in 2021. Decades ago, he said, "all the international experts" realized the importance of professionalizing traditional healers in Africa. By this, he was referring to the famous 1978 WHO conference at Alma Ata.

The conference's declaration stated that primary care:

> relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional

> practitioners as needed, suitably trained, socially and technically to work as a health team and to respond to the expressed health needs of the community (World Health Organization 1978:5).

The Alma Ata document, broadly, put forth an ambitious vision for universal primary care emergent through cycles of community engagement, locally-driven organizing and grassroots participation in the design and staffing of socialized healthcare systems. Traditional Healers "are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices" (63) the report noted. The conference participants were less interested in deferring to that local knowledge as much as to a vision of enfolding these traditional practitioners in a collaborative biopolitical project, along with nurses, doctors, community healthworkers, barefoot doctors and community organizations. In a line that almost directly resembled Bangura's introduction to me, the Alma Ata report noted that: "With the support of the formal health system, these indigenous practitioners can become important *allies* in organizing efforts to *improve the health of the community*…It is therefore well worth while exploring the possibilities of engaging them in primary health care and of training them accordingly" (63).

Of course, neither Alma Ata's ambitious vision for universal primary care nor for organizing among healers, activists and healthworkers came to fruition, undermined by global economic woes, lost momentum and the ideological shifts in post-Cold War global public health. When one studies the WHO reports and strategy documents on Traditional Medicine in the forty years since the Alma Ata conference, through structural adjustment and the subsequent explosion of non-state actors across the Global South, one can read the neoliberalization of global health written into the shifting ways that this problem-space was analyzed. Gone is the vision of grassroots inclusion, community ownership over health development and robust, publicly funded

health programs that were espoused in 1978. Now, quantitative studies on the use of traditional medicine, debates on licensure and liability issues with traditional practitioners, and concerns about the intellectual property of herbs all color WHO documents. Traditional healing is alternately portrayed as a market opportunity, a topic of technical and quantitative social science research, or even a kind of replacement for the now long-gone vision of constructing accessible, ambitious primary healthcare systems for all.

The WHO strategy report from the early 2000s that had inspired the formation of the first Union of Traditional Healers in Sierra Leone is emblematic of these new foci:

> This Strategy promotes the integration into health systems of traditional medicine practices and medicines for which evidence on safety, efficacy and quality is available and the generation of such evidence when it is lacking. In this context, 'integration' means increase of health care coverage through *collaboration, communication, harmonization and partnership building* between conventional and traditional systems of medicine (World Health Organization Regional Office for Africa 2001:1).

This document offers a rational-choice paradigm to suggest that traditional medicines' *availability* over biomedical care is the key reason why people continue to use traditional medicines, in addition to what the report calls traditional practitioners' "gentler means of managing" growing chronic diseases like cancer, mental disorders and heart disease." The WHO encouraged all countries to acknowledge the widespread use of traditional medicine so that the efficacy and danger of this alternative pharmacopeia could be tracked alongside its affordability, accessibility and even its "cost-effectiveness." (As if it pivoting-away from a narrowly-defined biomedical model of health systems strengthening might save donors money.) And, in a line that seems to jumble all epistemic order, the strategy encouraged States to: "advocate the rational use of TM/CAM [traditional medicine] by promoting evidence-based use of TM/CAM" (World Health Organization 2002; World Health Organization 2005).

The buzzwords used in this WHO document are familiar from consultant reports and NGO development strategies produced in Sierra Leone today—*collaboration, communication, harmonization and partnership*. This language is often used to describe in vague terms the possibilities for improving relationships between the myriad actors that have proliferated across the Global South health as public health systems continue to falter: nurses and doctors, NGOs and the public healthcare system, NGOs and other NGOs, scientists and clinicians, patients and clinics, para-institutions and para-statal institutions. These terms evoke a neoliberal imaginary that a calibration of the non-state actors at play in the Global South is what is needed to improve the health of populations—to tinker with the pitches and tones and rhythms of the NGOs and civil society groups, the traditional healers and the humanitarian nurses to create "harmony"—rather than a structural reorganization of health resources and priorities, or publicly-funded and managed national healthcare systems. In a place where clinicians find themselves almost always lacking the drugs they need to treat their patients and traditional healers like Mohamed say they lack the money to appease their *mami wata* spirits, *harmony* is upheld as the object of global health work, not resources.

But in this dank office in Kono, a group of healers continued to grapple with, dream about and push ahead that original Alma Ata vision of integration, mutual respect, and primary care linked to community organizing. Bangura and his Union kept alive a vision of an otherwise, even while adjusting their pitches to the neoliberalization of global public health. The Union had been invited to many donor-driven workshops on encouraging patients to attend clinics, they said, but none of those I spoke with told me of a single donor or government initiative that had actually offered resources towards the Union's vision for bureaucratization—or even recognized the potentials of their remedies.

When I met a Union member during the COVID-19 pandemic, he said to me: "When something like corna happens, donor-dependent countries like Sierra Leone turn to Russia, to China, to the US and UK for vaccines and treatments. Nobody anywhere in the world knows about corona when something new like this happens. Why not give our own medicines a try? *Why not even let us try?*" The recognition had not come, would not come, and yet Bangura and the Union still clung on to hope for an administrative office, streamlined referral process and a donor-funded herbalist hospital.

"Caring" for Imaginaries

Field Marshall Dr. Sulaiman Kabba executed spectacular displays of postcolonial esoteric power. Chairman Bangura and his associates held serial meetings to elucidate the visions of the donor who finally would come and recognize "tradition." People around these two—my research assistants, and to some extent their own colleagues— seemed both amused and impressed by these men's ambition, their meticulous labor of organization amidst a social and political landscape that is often characterized as decentralized, chaotic, rife with jealousy, conniving, cabals and patrimonialism. "That man is good," David said after hearing Dr. Kabba speak of his initial efforts to solidify the Union as a departure from the country's partisan politics, "trying to see what can be done if everyone joins hands together."

Kabba and Bangura spoke to different publics and drew on different ideological registers. As Samuel Anderson notes, one could argue that both Kabba and Bangura were "simply throwing concepts together and seeing which ones stuck…all ultimately steered toward justifying Union activities." Despite the recourse to the term "traditional," it was unclear what

that term even meant to them, or what unified their space of healing as separate from secular, "Western" medicine. After all, the whole domain of healing that the Union oversaw seemed at every level to reflect the secular: from re-branding to referral systems, this was a kind of emulatory model from the top (Kabba) to the bottom (Bangura). As Anderson writes, "integrating local and foreign languages of power [is] a vital art in contemporary Sierra Leone," in no small part because of the palimpsestic histories of humanitarian intervention and current landscape of whimsical flows of donor resources. There was an absolute brilliance to both these men, having absorbed, reflected on, and so deftly integrated various forms of expert discourse to which the country had been subject into their knowledge of cultural landscapes of the place—whether for recognition or as a very real way of standing out in the economy of postwar development aid. They may not have gotten much money for their efforts, but both did captivate an audience: of local people, of anthropologists, and very likely of some development technocrats along the way.

After several weeks of interviews and observation with Bangura and the Union, though I continued be profoundly impressed by their cosmopolitan agenda and discourse, I began to think about what all this mimesis *does* to patients trying to navigate landscapes of health and care. I had the sense that these healers had also come to emulate a certain discursive register characteristic to the NGOs and donors, health policy consultants and WHO experts in which I had been immersed: that is, a familiarity with—even an expectation of— the vacuousness of claims to care in an economy of global health aid that has abandoned ambitious visions for health equity. Patients, their health and wellbeing, were not the objects of either Bangura nor Kabba's imaginations nor their claims to supremacy and authority; rather, bureaucratization and changes in "mindsets" and "mentalities" were. And herein lies the perils of a landscape of global health

and care so saturated with this kind of imagination unmatched by resources: what may appear at first ambition and "thinking big," can, upon another type of scrutiny, come to seem an alibi glossing over a vacuum of know-how and infrastructures of care.

In Sierra Leone today, with so little funds to fund routine health infrastructures or services, plans and protocols laying out visions for humming and efficient global health bureaucracies, have, increasingly, come to stand in for global health work itself. Anthropologist Susan Erikson coins the term "document alibi" to scrutinize the "slippery social spaces between actual life-saving and appearances of it" in contemporary global health governance. "Document alibis can hide what has not yet been accomplished in Global Health Security," Erikson writes, or, I might add, can hide what *never can* be accomplished given the current politics of global health and care. "Caring for the documents can stand in for caring for people simply because the means to produce the paper and digital documents is available when resources to care for people are not" (Erikson 2019).

In 2019, I witnessed this "caring for the documents" firsthand. At one of the fanciest hotels in Freetown (itself run, and profited off of, by the Sierra Leone Government), I attended a workshop organized by the World Health Organization to revise the healthworker infection, prevention and control policies. Three years beforehand, up to 20% of the country's health workforce had died from Ebola (Government of Sierra Leone 2015), largely because of the inadequate protective equipment and protocols for handling infectious patients. I was seated at one of a dozen or so round tables, assigned to "Occupational Health and Post Exposure Prophylaxis." Most of my table-mates were nurses, or worked in various departments of the Ministry of Health. The young man sitting next to me was one of two doctors at a rural district hospital, pulled for the week from his post and patients.

We were tasked with reading the country's old infection prevention and control (IPC) policies and editing them to our specifications, which we would then read out loud to the room. These old IPC policies were reportedly written by a consultant during the Ebola epidemic—clearly someone with little knowledge of the country's health system, as evidenced by the long section on hygiene for advanced dental surgery equipment which existed nowhere in the country. An older man with a laptop and the policy documents sounded out the words slowly, while most at the table played on their phones. When the man got to the section about what to do after sex with an HIV-positive person, the table erupted into laughter. One middle-aged woman, through her giggles, said: "Use your ABCs—Avoid Body Contact!"

My tablemates primarily offered edits on typos, to separate the paragraphs, for instance, when "*dɛm jɔyn jɔyn"*. At times, one would look up from their phone to rehash a nugget of public health mandate. When describing what to do with breastfeeding if one is exposed to HIV, a nurse interjected (to no one in particular, it seemed): "But breastfeeding is important for the baby! Because of the Poverty Rate!" Another: "The woman should have gone through PMTCT [Prevention of Mother To Child Transmission]! Yes! So the baby should not have HIV!"

As we worked, the WHO consultants who had been flown in for the workshop walked around the room in navy-blue WHO vests, looking over our shoulders. When an Egyptian WHO worker came to our table, the Sierra Leonean physician next to me asked: "Why am I seeing something about carpel tunnel in an IPC document?"

"I didn't put that in! This is the existing document—this is what you people felt was relevant! At the time. This is your document, you wrote it, I just presented it." The consultant emphasized that this was a ground-up, organic effort to design protocols with local specificity and expertise, and added: "Put in what you think is important!" I thought of all the times I had

read, and made, the critique that technical health development programs do not adequately consider local knowledge, realities, perspectives. And yet, here, the WHO in collaboration with the Sierra Leone Ministry of Health had pulled an assortment of variously qualified government bureaucrats and healthworkers from their places of employment to write the national infection control policy for which they had no assurance of material support nor feasibility.

The following day, we began on the final section: a meticulous protocol for post-exposure Hepatitis B vaccination for healthworkers who have been exposed to the virus. I remembered from my days working at the clinic how frequently staff would be tested—often before giving blood for one of the organization's anemic patients—only to find out that they had tested positive for Hepatitis B, initiating a terribly uncertain process of clinicians trying to explain the nature of chronic infection, the likelihood of viral clearance, the ambiguities of the test result, the hope that before the infection caused too much liver damage some treatment might arrive in the country. One of the organization's beloved drivers had died that year of liver failure from hepatitis B, and the adult wards of the hospital always had young patients with ballooned abdomens from cirrhotic livers. The disease is rampant in Sierra Leone, and there is no public adult vaccination program in the country.

At the IPC workshop, reviewed the recommended schedules for viral load counts, the proper schedule for the vaccination booster, strategies for counseling exposed healthworkers. My colleagues were quiet, other than to ask, at times: "Where is the reference for that?" I was troubled by the way that they participated in this imaginary exercise. It seemed natural, in that room, that working on a *plan* on *paper* would be paradigmatically divorced from the actual possibilities for care or security. In fact, at times the healthworkers at the table seemed to recapitulate the vacuousness of the exercise in the ways they interacted with each other,

repeating public health scripts and mandates untethered from context. Nobody brought up that this effort was imaginary; that they were being asked to write out a protocol for a lifesaving vaccine—for a disease of which some of them would likely die—with absolutely no plan to bring the vaccine to the country. The work of envisioning and planning for global health delivery was just that: a labor of envisioning and planning. The WHO consultants also must have known that futility of the exercise, but there was a kind of collective commitment in the room not to unsettle this act of social imagining—through which, like Mohamed's nocturnal world of *mami wata* spirits, images of abundant vaccines, gloves, medical equipment and infection control specialists and other forms of unreachable medical modernity could be projected.

I wanted the healthworkers to speak up on their own behalf. Of course they knew the hollowness of this whole endeavor. But nobody voiced a critique. Collective imagination was the task at hand. Towards the end of the day, I spoke to the doctor sitting next to me: yes, he said, he was well aware all this was a matter of just putting "words on a page" and that ultimately it would be "left to God." But the government salaries were so unpredictable that the per diem offered through the workshop was a lifeline. Indeed, another nurse next to me said she had recently returned from the United Kingdom as a single mother to work in the Ministry of Health, and that the salaries were so delayed that month that she was worried she would not be able to take care of her child. It was not that the healthworkers in the room were blind to the hollowness of their policy-crafting. Engaging in this kind of imaginative labor was the very essence of global health work, the economy through which their livelihoods were sustained and connections with transnational institutions maintained.

Thirty minutes later, we were called for tea break. After grabbing cookies, the nurses gathered their things to depart, collecting the empty water bottles from the tables on the way to

sell in their villages. The doctor wanted to go himself, but the man reading on the computer said we should continue. “Ummm…so we are just going to leave [this all] in black and white [as written words], it’s not like we are actually going to do these things,” the doctor finally said. That was the only time I heard any of the participants question the premise of the exercise, and it was so surprising as to strike me as a transgression. “So I think we can go.”

This was global health policymaking in real time. The workshops, the policy meetings, the stilted conversations between funders, technocrats and Sierra Leonean health officials around board-room tables in the Ministry of Health, peeled off from the conditions of health and care but emphatically partaken-in by experts of all cadres. The salvage economies of daily sustenance allowances, hotel buffets and empty water bottles to distribute to kin back home that are often the only material condensation of all this labor. Still, these economies generate much jockeying, among underpaid nurses, rural doctors and traditional healers alike, to participate in these exercises.

Dr. Kabba and Chairman Bangura seemed almost carried away by their visions and ambitions; the healthworkers at this conference seemed to be going through the motions. And yet, in all three cases the epistemic practice was similar. This imagining global health—from the high levels of global health policy to traditional healers on the ground, whether it is framed as “faking” (Erikson 2019) or “dreaming” (Geissler and Tousignant 2020)— coalesces into a repertoire or order of sorts that extends outwards. What, in this context, makes one a healer or a medicine man? Is one’s role as a healthworker—the work that that entails, the ladder one climbs for therapeutic or professional supremacy—tethered to the practice of delivering care, or in this context structured by the political economy of global health, mastering imaginative articulation? This is the dilemma that patients themselves face as they discern the possibilities for securing

care: global health work in Sierra Leone today is in many ways constituted by a shared language and habitus, a theatrics—among the WHO experts, the doctors, the NGO workers, the bureaucratizing Traditional Healers —of imagination, or, depending on how you look at it, disingenuity.

Supervising Life

Back in Kono, Chairman Bangura's ultimate vision was that the healers and doctors would come to a point of mutual appreciation and institutionalized collaboration. But he made it clear, at least in his conversations with me, that he was aware of his medicine's reputation as inferior in the eyes of public health technocrats, funders and practitioners.

> To start with, traditionals don't have dosage. We don't have measuring portions in our medication… Medical is a power. *Medical is a supervision of life*. Tradition is just coming in to enforce and buttress the effort of medicine. We know this. So we …can't go without hospital, the technology there holds the life…But we traditionals cannot testify all this area, all we know is the way we see and understand fetishism, witchcraft, whatever means of evil—we target it.

While Bangura emphasized again and again the healers' subordinate positions in relation to *"*medical medicine which is the supreme power that supports you and me," some of his colleagues told me that they had given up on the possibility of a productive working relationship with the hospital, suggesting instead that the healer's Union create their own facility.

At a certain point, I began to wonder, like Claude Lévi-Strauss (1974) in his famous essay on Quesalid the Northwest Indian Shaman, what Bangura's relationship was with his own expertise of fetishism and witchcraft. Was he a quack—would he acknowledge that? Or was all

this bureaucratic expertise a unique niche Bangura had mastered as a profession, a livelihood? Lévi-Strauss argues that these questions of individual, internal dissonance, self-doubt or disingenuity are beside the point. Quesalid's efficacy was derived from his audience's consent, appreciation, and continued desire for the Shaman's services. For the leadership of the Traditional Healers' Union, perhaps efficacy would not be derived from patients' reactions to their care, but through recognition from the World Health Organization and the Ministry of Health, donors and meandering anthropologists— or at least the continued tinkering towards harmonization, the alignment of vision, focus and discourse among all these actors in Kono's political-economy of global health.

Chairman Bangura's line: "medical is a supervision of life" stuck with me, perhaps for its resonance with Michel Foucault's (Foucault 1990) own definition of contemporary biopolitics: a regime that seeks "to ensure, sustain, and multiply life, to put this life in order" (138). For while in this case Bangura sought to differentiate between the work that *traditionals* and *medicals* were each engaged in, earlier he had said that all healers were "in the same mission: improving the health status of the people of Sierra Leone." Perhaps this mission, this particular biopolitics that both Bangura and the Union, the doctors, the WHO technocrats and the NGO workers were all advancing, was more an effort to put *things* "in order"—to "supervise" the actors, institutions and sources of care—than to intervene upon the health of real people in Sierra Leone.

Medical Pluralism in Real Time

Throughout my visits to the Union, the girl with the swollen face I had met on the first day continued to live with her mother in a dusty shack at the edge of the compound. She also

appeared more emaciated each day, her breathing louder each time I came. Towards the end of my visits to the Union, her face had swollen to larger than her torso, her chin so enlarged it jutted out as if it had been stuffed with socks. Her cheeks were further swollen, and there was so much pressure underneath her skin that her eyeball looked like it had come out of the socket. When she opened her mouth, I saw that her lower gum was bleeding so profusely and swollen that most of her bottom teeth had been forced out, and with each breath she took she made a rasping, rattling sound from her airway that was nearly shut from the swelling.

The girl's mother, a young woman in her thirties, said that they had originally come from a distant village in Kono, but had visited nearly all the major hospitals in the country with no success. As a last resort, her relatives had recommended that they try the "native side," and she had acquiesced, despite some ambivalence. Jennifer, the girl, was unable to talk, and, by the time I sat down to hear her story, Sia seemed resigned that her daughter was probably going to die, slowly and painfully. One of the Union members barged in and told us to leave—this was a "witch problem," they knew what they were doing, and we didn't understand. But Bangura yelled back: "Nevermind! They have their ways, we have ours."

Sia told me their story:

> One day, Jennifer was sitting in her exam and she began to feel sick. I began to see water coming out of her ears—white. It was like water.
>
> They called me in the village that water is getting out of her ears. Small, small, like a raindrop. That lasted for some hours, just for that day. She was crying, and I wanted to give her Tramadol.[35] The pain was in the head, in the cheek. She can't feel anything… After the swelling began, she got hot. She got hot, and sores in her mouth. It began to bleed from the gums. The bleeding came every day, blood, just coming, every day, like this. You can see.

[35] A widely available opioid.

> We have spent a lot, we have spent a lot. We went to Massanga.[36] I went to the Spanish people.[37] I was there for 17 days, but no medicine. They called Emergency,[38] everywhere, I wanted to go to the Chinese people too.[39] They told us that they have the medicine, but the medicine is too costly to put the swelling down. But they called Emergency Hospital, no way. Lunsar:[40] no way. Makeni:[41] no way. Magburaka:[42] no way. I have my documents.
>
> They found the medicine but they could not get it. It was a white doctor, one was called Alex.
>
> There was no medicine. It was like I was a useless person staying in a hospital with no medicine. But the Whites were, anyway, nice to me because they were sympathizing with the kid. So they called Emergency, they called Magburaka, they called Lunsar. They never got the medicine. So I just went off by then.
>
> I told them that, if you go to the hospital, if you don't have the medicine, why can you stay there? You can find no way. I told them that if I have money, I may take my daughter to Freetown, but since they called and said there was no medicine I did not go.
>
> I don't know how they called the sickness. But yes, they had a name. But I don't know it. They said they have medicine for this in Europe. But the medicine is very expensive, so they cannot take the medicine for only one child like this. So the other doctor, she has left to Holland, she promised me that maybe it is not true, maybe she can get some.
>
> Jennifer is so sad. Just now she was crying. She said: 'Look at me, I am a foolish girl!' I also started crying. I said: 'It is not your fault, don't mind it.'

I had heard many stories like this over the years: patients' expansive, persistent trajectories of seeking care, from one humanitarian hospital to another. But I had never heard such a gut-

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[36] A hospital in the center of the country supported by a Dutch NGO.

[37] A colloquial reference to a Catholic hospital in the far West of the country, operated by Spanish missionaries.

[38] An Italian NGO surgical hospital in Freetown.

[39] There are several new Chinese hospitals in the capital, sponsored by the Chinese Government.

[40] The Spanish Catholic hospital.

[41] A Government hospital in the center of the country that frequently has humanitarian mission groups.

[42] An MSF-sponsored hospital

wrenching account of one European NGO worker after another explaining that a cure was out there—that they "had a name" for it—but that Jennifer, being "only one child like this," would not galvanize the cost nor effort. Sia made clear: she knew Jennifer's problem was not a mysterious, yet-unnamed one that must be dealt with through the epistemologies, diagnoses and techniques available at Union. At each stage of Jennifer's seeking care, the European doctors had articulated that her problem was familiar and treatable with a particular medicine. But, each time, those Europeans made clear that that medicine would remain out of reach, and in so doing reified Jennifer's abjection and the near-term certainty of death. Faced with no other option, Sia and Jennifer "just had to try" at the Union.

Sia was not satisfied with the care that Jennifer was receiving under the Union's watch. The herbalists handled the girl's head gruffly, pointing out to me the herbs they had rubbed on her cheeks, but Sia seemed unconvinced. Amidst all the fanfare of our visits and Bangura's demonstrations of the Union's bureaucratic prowess, the two had remained somewhat distant in the corner of the compound, uninvolved, and the healers had made no mention of the two of them either. When Sia told me her story, I stressed, as I often did at the end of interviews, that I was not a doctor but that I could try and find a way to bring her to the Ichende clinic where the clinicians might be able to help. Sia immediately agreed. I asked Bangura if he would accept this plan—just to get another "medical person's" opinion. He stumbled, wanting to discuss it more, but Sia was already packing her things. We called the Sierra Leonean physician who was at the clinic, and after my inarticulate attempts to describe what I was seeing he said he thought her condition might be an easily-treated staph infection. Jennifer and Sia took off ahead of me to the clinic while I explained to Bangura that I would be back to hear his thoughts about the girl. A

crowd of angry-looking healers was forming on the lawn, and I walked backwards out of the yard and jogged to the main street for a motorbike to the clinic.

I knew then that a dying fourteen year-old girl and her mother now looked to me as a broker of lifesaving care. It was clear from her account that she had before looked at Alex, the Chinese people, the woman from Holland the other European volunteers in the same way—they had all let her down, and what this did to her expectations of me, after such a long trajectory, I did not know. But this narrative of one expatriate physician after another throwing their hands up made me feel just that much more implicated. I certainly had no sense of what care Ichende could provide Jennifer in her condition, but I did not want to be another false-start named in her posthumous narrative. This situation was ethically untenable, but also real, inescapable, inevitable— and the Ichende clinic probably was the possible avenue to access a cure at this point, if one existed. What are the standards one can turn to in an encounter like this, this raw, encounter with pain, desperation, inequity, ambiguous diagnoses and prognoses—but also the slim potential of a hopeful outcome?

But I was struck by how readily Jennifer and her mother shifted modes, how quickly they packed their bags and left. Jennifer had been covered in herbs; at the Union, they were fully partaking in the treatment. But in telling her story, Sia made clear that she was not fully invested in whatever the "traditionals" offered, and that she had come to the Union as a last resort and after being pressured by her neighbors. There was urgency to this trajectory. If Bangura wove the technocratic logics of neoliberal global health through his formulating a network of healers so that something that defied binaries of biomedical/traditional, herbalism/professionalized healthcare system emerged, so too did Jennifer and Sia's trajectory of care-seeking elude the binaries espoused by the NGO healthworkers in Kono and public health researchers in Kono on

"clinic uptake" versus "use of traditional medicine." Theirs was an impulsive shift from one source of care to another as new opportunities for potential resolution became available; a fluid patient subjectivity: open to the possibilities of resolution but simultaneously skeptical, hesitantly knowing that what the healers, the NGO clinics, the ex-patriates, the government hospital offered might very well help, but could also just be words, or empty and hollow claims and promises. "Where I feel uncomfortable with some of the writing on African healing systems is in the assumption which I suspect underlies it," historian of medicine Megan Vaughan (1994) writes, "that because the body and illness in the body are arenas for the negotiation of social conflict and misfortune, that this somehow makes healing in the African context a benign and benevolent process from which all parties emerge feeling physically and psychologically better" (293). Sia's abrupt, frantic shift was colored by the reality of Jennifer's pain, poverty, social and physical dejection as much as any coherent integration of epistemic systems or beliefs; her journey a punctuated series of swerves towards and collisions with new possibilities for care, all motivated by the desperate need to take the pain away.

A few hours later, I found Jennifer lying on the veranda of the clinic. An Ichende nurse had taken one look at the girl, and asked "Why did you bring her here? … If we had the medicine, you would see the miracle of modern science. But without it, there is no way." Jennifer's condition was Burkitt's Lymphoma, an endemic form of childhood cancer that kills by slowly constricting the patient's airway as lymph nodes in the throat swell to the size of tennis balls. One of the NGO hospitals in the country used to have a treatment program—which required a simple, and relatively inexpensive form of chemotherapy—but had abruptly ended it with no plans to initiate services again. Jennifer was dangerously anemic, so we arranged for several blood transfusions at the government hospital and the nurse gave her oxygen to help with

the breathing. But without the drug, there was no hope for resolution other than definite, perhaps prolonged, death.

Years of work in Kono had often brought into such sharp relief the near impossible social, political, historical complexities that subsume magic bullet and technical improvements to peoples' health. But in Jennifer's case, her life or death seemed then to hinge so clearly on access to one vial of chemical, one substance that existed in plenty in other parts of the world. An answer was out there, there seemed no ambiguity in that. Inject it in her vein, and her pain, her suffering, her dejection and the imminence of the death she knew she faced would likely be gone.

All the foreign volunteers at the clinic emailed home that afternoon, asking everyone they could think of for connections to an oncologist. Sia wanted to bring Jennifer home while she waited, for the privacy, to reconnect with her family, and because food was so much less expensive in the village. After five nights of little sleep, the sound of Jennifer's gasping for breath running through my head, a lead came through: an oncologist in Alabama, had agreed to send the cyclophosphamide treatment to a recently-returned volunteer. He in turn mailed it to the American physician, Tom, departing the U.S. for Kono soon. The treatment arrived a week later. By this time, Jennifer had become completely blind as the pressure crushed her optic nerves, but Sia kept repeating: "Life first, then the eyes." Tom lost his baggage on the way to Sierra Leone including the cyclophosphamide, but, when he arrived in Freetown, learned, after all that, that the drug was readily available at a pharmacy in the capital city.

In Kono, Tom administered the chemotherapy to Jennifer, who by then seemed only days away from death. In the District hospital there was no laboratory that could monitor her blood electrolyte levels or organ functions, reliable electricity or consistent staffing. Tom said he hoped

that the rapidly-disintegrating tumors would not cause kidney failure and an even quicker death. When I learned of this potential consequence of the treatment (called tumor lysis syndrome), I became uneasy that there would be no way to convey to Sia adequately the potential risks and uncertainties. But the American physician charged ahead with the chemotherapy. Indeed, Jennifer's swelling quickly went down and her breathing seemed almost normal again. She was blind, but her face returned to its original shape. The day before I left, when she could finally speak again in muffled, slurred *Krio*, I visited Jennifer in the female ward of the Government Hospital. She was wearing a bandage over face to absorb the puss draining out of two tracts that had appeared on her chin. In the dim, acidic-smelling room, she positioned her blind eyes on my face: *"I don't understand why you people have done so much for me. Why I deserve this. Why do you do this for me?"* I couldn't think of an answer to give her. Her question was even more painful and raw to hear knowing that she had been told so many times by other Europeans that she would *not* get treatment, would *not* get the drug—that her own health and the integrity of her body could *not* be restored. What a horrible, indicting aporia she now faced: why she should *"*deserve" care and life itself. I did not know what to say. As if in some perverted parody of its vapidness, the NGOs' motto was suddenly on the tip of my tongue: "Because Every Life Matters." Vacuous discourse is indeed convenient to turn to when there is nothing else to say.

All the women sitting in the ward stared. I said I couldn't wait to see her next year looking again like a normal girl and left.

On the fourth cycle of chemotherapy, after I had returned to the U.S., Jennifer's condition rapidly declined: she was found convulsing and confused in the middle of the night by a nurse and was dead by morning.

In Kono, fragmented flows of health resources overdetermine landscapes of health and care. It seemed at first so unfathomably unlikely that Jennifer's trajectory of care seeking would cross paths with my meandering inquiries into local healing, but then again, then is the very terrain in which patients scan for care. Jennifer and her mother had intersected with many others humanitarian sites of care beforehand, informed early on that a resolution to their problem existed, but it was out of reach. The two embarked on a personal and geographic migration across the country, searching in vain for one person with a web of connections that might lead to a pharmacy with the necessary drug in the United States or Europe. They seemed already to have withdrawn and become resigned to fate at the Union office, as Sia watched Jennifer slowly wither and as Bangura continued to proclaim his supremacy as a bureaucrat and leader. But it was after that withdrawal, after their movement ended, in fact, that we had crossed paths—not even in a healthcare facility but at the compound of the Sierra Leone Indigenous Traditional Healer's Union.

Saturated by transnational networks condensed into the form of NGO workers and donor-sponsored care, humanitarian clinicians and anthropology researchers, life chances in Kono change in leaps and bounds as lives and networks intersect with bewildering arbitrariness, even as, in the end, death remains the omnipresent likelihood.

Chapter 3: *Mɔtalman*

Introduction: Two Scenes

The clinic was built on the crest of Konguemeh's steep, washed out hill, so that as I sat on a wooden bench on the veranda, it looked almost like I could reach out and graze the treeline of the surrounding forest. A few days before, I had introduced myself to the few elderly people who happened to be at the town's central structure used for meetings. I explained that I was a researcher who had come to learn about the rural healthcare system in the region and asked them to tell me what they knew about the history of the town. Excited by my interest, the old men had finished each other's sentences about the warrior who settled the fortified village hundreds of years ago at the top of this mountain. Being able to see in all directions was all well and good, as was being a part of a warrior lineage—but now the problem was that the women and children had to descend the two-hundred foot mountain anytime anyone wanted water. I pointed at the rusted water tank that towered over the village and the spigot right outside the meeting structure. *Dry, dry, dry*, the old men said, and didn't remember when the plumbing had last worked. Some NGO had said something recently about fixing it—was that two, three years ago? Someone had showed up and measured the water tank, but still—*"no way."* Now the hill was just a burden.

I sat thinking about that meeting, as I listened with half an ear to Tamba, the nurse with whom I was staying at the clinic the next village over, and Gloria, the nurse in charge of Konguemeh's own clinic, speaking quickly. They were negotiating how to shuffle the few drugs they each had in stock at their respective clinics given that they had no idea when more might arrive from the District Health Management Team in Koidu. It was dusk, humid, the treefrogs awakening in the forests. Over Gloria's shoulder I saw David take a long drag on his joint. The

smoke from the *djamba* wafted up, mixing, it seemed, with the grey whisps coming from a cooking fire at the bottom of the mountain. David bobbed his head slowly, his eyes closed; it looked like one of his favorite reggae tracks was playing in his head. Then I heard yelling, and realized that while his eyes were closed, and his face was meditative, he was shaking his head slowly, with sadness. I got up and walked over.

He did not open his eyes when I was next to him and kept shaking his head. "This one…this is a *real* interesting one," he said slowly. At the bottom of the hill, I saw a man screaming out the door of his hut, and a young girl, maybe seven years old, walking slowly up. She sobbed, and a pot in her drooping hands banged against her knees with each step up the steep grade. "The way I am hearing it," David began, "this girl, she worked all day in someone else's farm. But she will only be given rice as a payment when it's harvested in three, maybe four, months. 'You go find rice, find rice in town if you don't work for money!' the parents have been yelling." I watched the girl continue to sob as she ambled up the hill towards the clinic where we stood watching. "How can you say this to a girl like that? Yes, she should have helped the family, but—but where is she supposed to get food at 7:30? They speak with such confidence as if there is rice but where would she find rice at this hour?"

It was a horrible scene. The father and mother continued to scream at the girl as she walked up the hill aimlessly. Where would she go in the quickly-falling darkness? If not to find food, then even just to pass the time in shame? I also wondered why this scene had so captivated David, why he called it "really interesting." During our stay near Konguemeh, we had learned much about the region's history, the vibrant cultural lives and the impressive agricultural projects of the Kissi-speaking inhabitants here. But the structural violence and the extent of people's physical suffering had also been a constant confrontation: the abandoned plumbing system, the

empty clinic, the hunger we had heard so many people speak of that week, the painful, unresolved illnesses we had seen at the clinic everyday. I had never seen David so frozen before. Was it because we were now seeing these structural issues unfold at such a granular level, within one family, in interpersonal cruelty? Did this fight represent a particularly transgressive breakdown of familial norms and relations under the burden of hunger? Perhaps David was so troubled that the parents were not just saying outright that the girl must go hungry for the night, but were displacing the situation onto the girl, as if it was a matter of her own volition to find food. Or maybe he was just tormented at watching a young girl confront the inevitability of the coming hunger-pains, pains David had experienced himself—and who knew when they would end?

I watched David, searching for some guidance of how I should interpret this whole situation, or some reassurance of absolution in his expression—something beyond the agony that I was beginning to feel as well. There was none to be found. David seemed unable to find the words to articulate why he was entranced by the scene, or what it meant to him. But he tried, as if he wanted me to witness alongside him, speaking in fragments. "How can people expose children to such a thing? *What….why….just….how…. can people do that?*"

*

On the night of November 5, 2021, in the poor, crowded outskirts of Eastern Freetown, a fuel truck crept out of a busy junction to take a sharp left. A lorry filled with granite pebbles hurdled down the road, perhaps with shoddy brakes or maybe just an overly aggressive driver. The lorry slammed into the fuel tanker; the tank began leaking. The drivers of the two trucks, anxious

about the flammable liquid, tried to warn the growing crowd of onlookers off. But hundreds of young motorbike *okada* taxi drivers from the junction ran to the scene to gather the leaking gasoline in buckets. The President of Sierra Leone had reduced fuel subsidies and the price of gasoline had skyrocketed recently; taxi drivers were not going to watch this lifeline waste. Those at the scene called friends to come fill buckets and jerry-cans. Traffic was gridlocked in all directions and several crowded busses stood still. The young men rushing to carry the fuel back to their bikes splashed gasoline all over the junction and market.

Ten, maybe fifteen—some said thirty— minutes later a match, a cigarette or maybe just a piece of metal dropped and sparked. Everything exploded. Two nearby petrol stations exploded as well.

I was in Freetown that night, far from the blast. But within a matter of minutes videos of the gruesome details began circulating on WhatsApp. In one video I received, one can hear screaming, motorbikes trying to flee the fireball, young men yelling "bike bike bike bike bike!" to try to ride out of the inferno. In another film, blackened, grimacing corpses pulled from buses are stacked in piles on the streets; they seem frozen in their seated positions. In the background, you can hear someone say: "*O layf, o layf, o layf* [oh life]*"*

In another, the man who is filming the fireball seems still. Some victims, with much of their skin and clothes burned off, walk slowly, dazed, away from the flames. The man filming seems at a loss for words, but does not sound anxious or frantic, more mournful. He keeps saying: "Oh my God, oh my God, *oooo, mɔtalman."*

Encountering the Violence of Everyday Life

In Sierra Leone, people often seem at an impasse of language when they encounter incidents of violence or death in front of them. They grasp for scripts like "*na God,"* or *"ehh, layf"* they shake their heads, they shrug their hands. Like David looking at the sobbing girl that evening, people sputter, as if unable to put into words what the horror in front of them signifies. Often, like the man holding a smartphone at the scene of the tanker explosion, they sigh: "*o, mɔtalman* [oh, human being.]*"*

Sudden illnesses and deadly vehicle accidents, fights on the street and lives upended by natural disaster, expanding diamond mines and demolished bridges are daily occurrences in Kono. The precarity of life itself, the life-and-death consequences of a cruel and indifferent world with little public infrastructure to mitigate contingency, is constantly in view. But when I have found myself face-to-face with a moment of violence or death, I am often struck by the ways in which those around respond. Sometimes there is a rush to grab the injured, to break up the fight, to *intervene* as an improvised collective. But often there is a stillness as people take in the scene. A child, face down on the road after being hit by a car, fingers twitching slightly as a trickle of blood spreads from his head: family members slowly made their way to the body while a ring of audience-members recorded on their phones. A brutal fight between a police officer and a street-boy, it looks like the boy might be seriously injured: the same kind of bated breath and silence from onlookers, shared looks of sadness, phones out. A woman unconscious and unresponsive, being wheeled in a cart from one hospital ward to another with family members rushing behind, sobbing: dozens of eyes turned to observe the woman in the stretcher, while

shaking their heads slowly. At all of these scenes, I have also heard people sigh, from a distance: "*o, mɔtalman."*

A few days after the fuel tanker explosion, I asked David to describe what *o, mɔtalman* means. He gestured more than he spoke, almost like he did in Konguemeh that night. Over the course of our conversation, this is how he explained it:

> *It* doesn't mean anything…
> Humans are nothing…
> *It's* all vanity…
> Human beings don't actually mean anything…
> Look what can happen to a human being..
> It's too horrible to let it happen to human beings…
> It's like… 'Look how *mɔtalman can sorry*…'
> A human being can really go through this kind of thing?...
> It's a big shock…
> Maybe if they [the observers] were as desperate as those people [who ran up to the leaking fuel tanker] they would have done the same thing…
> But it's [not empathy, it's] more like: 'Oh look what has befallen *them*.'

Mɔtalman is the *Krio* word for "human," as an impersonal or abstract being: "mortal-man." Thus, *o, mɔtalman* means, literally, *"oh human beings"* but in the singular: perhaps more like: "*oh, look at man.*" In David's rendering, it is a lament for the condition of being human in Kono and of being victim to that condition. But it also alludes to the fact that human beings have wrought the world of suffering, and is a comment on the violence *mɔtalman* can enact on each other. The political valences of the aside are left somewhat undefined. Is this an articulation of a state of the precarity of life in Kono—or even a comment on the value of life in Kono as maintained in a world so wracked with disparities, on the regimes of necropolitics at play? Or is *o, mɔtalman* a reflection of a condition though to be shared, across race, class, geographies? And the object, the direction of the refrain is often left ambiguous. In Konguemeh that night, was David's fixation the cruelty of the parents who drove out their child, or the misery of the hungry

girl? Can such an object of lamentation even be delineated? Or, is the condition of human beings to suffer and, overwhelmed by the tension and constraints of an impoverished everyday, to inflict suffering on others?

"O, mɔtalman" is not a disposition of voyeurism, nor does it reflect a numbness towards the suffering of others. On the contrary, the observers of death or a crisis (like David that night at the clinic) often look shocked and appalled. But as David narrated his reaction to that moment in Konguemeh, with the girl driven from her house, I was struck by how instantly the violence in front of him was framed as existential, not particular. He did not say: *"*How can *that mother* be so cruel," but rather framed the question as impersonal: "How can *people* do *these things* to *children?*" In a place in which violence and the proximity of death are (and are felt to be) so omnipresent, David immediately framed this particular situation as an indication of a broader— and perhaps intractable— condition. His comment was not just a critique of a family's parenting, but an assertion about what it means to exist as a human in Kono. It was comment on the fabric out of which familial lives in Kono are made and often unmade: a condition of struggle, poverty, arbitrary and capricious *sɔfanɛs* [suffering]. David was paralyzed in the face of being confronted, again and again, with this condition—not in a fatalistic sense, but as a way of actively engaging the suffering and noting that there was collectivity within it. This is a condition—the *same* condition— in which desperate motorbike riders willingly run up to a broken fuel tanker and are swallowed in a ball of fire and in which parents drive out their hungry daughter for not bringing a few cents home for rice.

Such a perspective on the nature of suffering was further explicated to me the night after the fuel tanker explosion, as I sat in the back of a taxi in Freetown as two men argued about the accident. The passenger in the front seat was insistent: poor or not poor, the young men who

were at the scene to gather the gasoline ought to have known better. At a certain point, no matter the deprivation one faces, one bears a responsibility to safeguard one's life—or, at least, one ought not to invite death so egregiously by running up to a tanker spewing out explosive chemicals. With public education, better accident responses, vehicle inspections, the passenger argued, this condition "can be avoided in the future."

The driver disagreed. Certainly the accident was horrific. But "how many hundreds or thousands of times" had a similar event occurred in Sierra Leone, he asked, in which the struggle for livelihood involves grave risks of death? How could the motorbike taxi drivers have known that *this particular* tanker would blow up? He agreed with the passenger: the deaths had ultimately occurred because of "the poverty." But what was one to do? Suppose everyone had run away from the scene—there was no equipment in the country to clean up the petrol. Such risks are an invariable part of the life of a poor man or woman in Sierra Leone: *to hustle for survival is also to face the possibility of death coming at any time.* These deaths were a result of meaningless, unavoidable bad-luck in a difficult world as much as any irresponsibility or ignorance.

As I prepared to get out of the taxi, I asked them: "If a gas tanker were hit today, and began leaking, do you think the people around would run away from it, or run up to take their chances that this time it might not explode?"

The driver: "Absolutely they will go up and try to collect the fuel."

The passenger, who had spoken with such derision about the conduct of the young men at the accident, thought for a second. "It is highly likely they will do the same thing again." These two men did seem so much resigned to the inevitability of death, as immediately attuned to the structural forces—the social and psychological lives of the pressing poverty— that linked death,

deprivation and the *okada* riders' own assessments of risk and relations to the future. The *okada* riders ultimately had little choice: confronting death one way or another—from poverty, a motorbike accident, or a cataclysmic explosion—meant doing what had to be done.

This way of encountering moments of suffering as crystallizations of deeply entrenched social conditions runs up against the logics of humanitarian action that home in on discrete moments of suffering and efface the broader contexts, structures and histories that produced them. The humanitarian gaze beckons intervention more than lamentation. As an ethnographer, I often feel caught, painfully, in between these two ways of seeing suffering. In Konguemeh that night, watching the girl sulk away to hunger, I knew that David's disposition towards her situation was born of his wisdom about just how complex the causes of such interpersonal violence are in Kono, the limited courses of action, the impossibility of capturing the girl's worldview, the unintended consequences that could unfold in the aftermath of intervention. I also knew that he had very limited means himself, and that he too faced periods of hunger throughout the year. The instinct to intervene with resources is itself a kind of privilege. But I also could not watch any longer the girl sobbing over an impending twenty-four hours of hunger that could be resolved with the equivalent of fifty cents. I broke David's silence by passing him a bill and walked to the other side of the clinic so I was not entangled as the benefactor. David nodded, stretched out his hand, did not make eye contact and said: "Take this, go find rice."

The girl quickly snatched it, looking at the ground. She muttered "Thankyougodblessyousir," and walked more quickly up the hill. David seemed visibly relieved, as did the girl. No doubt this small resolution was some form of care, but swept up in the pathos of the moment, David's encountering it, and all the layers and layers of complex forces, economies and relationships that had produced it, I had no illusions about what we had just done.

Health, Wellbeing and the Impossibilities of Care

In this chapter, as I explore four patients' extended narratives of falling ill and seeking care, I consider how this disposition towards the nature of suffering and violence, the sense of an intractability to physical suffering in Kono, becomes embodied. As patients with chronic or serious health conditions search for care across fragmented healthcare systems in Sierra Leone, their resolve to carry on is dependent on maintaining faith that their illness is discrete, a bodily condition for which care, or cure, is possible. At every step in the process, injunctions to seek out services from the healthcare system in the form of posters, radio programs and other NGO outreach campaigns encourage patients to *desire* a restoration of their health. Individual clinicians claim certainties over patients' conditions and promise resolution. But as poor patients run up against the constant material gaps in hospitals, bureaucratic neglect, the let-downs of individual clinicians who fail to deliver on their promises, and the limits of their own agency, maintaining faith in such a pursuit is not easy, and may come to feel utterly irrational. Often, they withdraw from the pursuit entirely, and set their sights on a different notion of wellbeing than one premised on the restoration of bodily function alone.

In considering why patients might withdraw from seeking healthcare in Sierra Leone, anthropologists and public health researchers often draw attention to the substantial financial resources required to visit hospitals and specialists in the country. "What may appear to be inaction informed by fatalism—even avoidance of proffered medical attention—must be understood as a calculated decision about the costs and benefits of expensive care, based on experience," Mariane Ferme (2014) explains of many rural Sierra Leoneans' reticence towards

the healthcare system. The stories I recount here involve patients' multi-year journeys from one hospital to the next, and the time spent away from farms and families can be financially devastating. The costs at private and public facilities can quickly run into the thousands of dollars, which is far more than a year of income for many rural Sierra Leoneans. When patients do manage to cobble together the resources for lifesaving care, they may face (in the parlance of health economics) "catastrophic expenditure and impoverishment" (e.g. Duinen et al. 2021) in the aftermath with possible consequences for generations to come. Sometimes, by the time patients withdraw from seeking care, they are substantially worse off physically and financially than when they began.

However, when I have met people in their homes after withdrawing from one of these journeys across the country and coming to live with the debility they had initially sought to cure, they do not seem in a state of anxious waiting for the cash, nor do they seem simply eager to return to the hospital as soon as someone pays the bill. Patients often describe their returning home not as a matter of being broke, but in the words of one woman (recounted below), because they get "tired." Questions of how much resources are worth spending in pursuit of care become bound up in more existential considerations about what wellbeing is, the nature of struggle and suffering as an inescapable part of life in Kono, and how physical debility may ultimately not be able to be overcome, but can be lived-through nonetheless. *Withdrawals are often accompanied, in other words, by epistemic, affective and philosophical shifts vis-à-vis how patients relate to their own embodied conditions.*

How one defines health, and how one conceives of bodily restoration in moments of illness, are inevitably more complex considerations than the repair of bodily function alone (as if

even that could be defined).[43] Anthropologist Michael Jackson, always concerned with how meaning is made of difficult conditions the world over, writes that "Well-being [always]…reflects a sense of discontinuity between who we are and what we might become" (2011:ix). For the Kuranko people with whom Jackson worked in northern Sierra Leone, he argues, the capacity to "manage" amidst life's contingencies and crises, illnesses and struggles is an extraordinarily important cultural value. "It is how one bears the burden of life that matters, how one endures the situation in which one finds oneself thrown," Jackson adds. "Well-being is therefore less a reflection on whether or not one has realized one's hopes than a matter of learning how to live within limits" (2011:60-61). We might consider how this notion of well-being could shape one's relationship to care: might the objective of care and of seeking out healing be the capacity to tolerate and make-do through debility, rather than the alienation and resolution of discrete bodily phenomena? "[The] view that impoverishment is never simply a lack of income but a deprivation of opportunities to exercise one's ability 'to achieve various valuable functionings as a part of living,'" Jackson continues, quoting Amartya Sen, "is a valuable corrective to those who would reduce well-being to material circumstances or see it as a mainly clinical question of physical or mental health."

Jackson's work calls for a careful engagement with what patients in Sierra Leone desire or expect out of their bodies, health and care. Certainly, neither wellbeing nor "health" ought to be reduced to "material" or "bodily" conditions alone. But the stories my interlocutors tell also convey a sense that these relationships to the centrality of struggle, suffering and the value of

[43] I do want to state at the outset that I in no way intend for this discussion to convey an ableist perspective. In speaking of "bodily restoration" I try to think with my interlocutors as they encounter embodied sensations (pain), structural barriers to inclusion in social life and livelihoods, the socioeconomic implications of injury and illnes in this context, and the promises of care. I certainly do not intend to be read as validating or glorifying a particular bodily state or ability, but rather staying close to people as they experience illness and changes in their bodies and try to define what healing and care would look like for themselves.

learning to bear one's lot—in other words, the "discontinuity between who we are and what we might become"—are also constrained by material conditions of possibility. The cultural value of "endur[ing] the situation in which one finds oneself thrown" cannot just be read synchronically, for this value is modulated by the structures that so limits people's life-chances and ability to flourish in, rather than just bear, the milieu into which they are thrust. Likewise, people with painful or debilitating illnesses who simply cannot maintain further pursuits of care do not return home to languish but assimilate the experience into ongoing struggles for a better-than-now wellbeing amidst degrees of suffering that may feel immanent and inescapable.

Here, I explore the stories of four people who faced chronic or serious illness in Sierra Leone. First, I follow David's frustrating and at times tragic efforts to find definitive care for a bladder tumor in 2020. His travails provide a powerful picture of the nightmarishly bureaucratic nature of hospitals in Sierra Leone, the forces of exclusion that can drive even a patient with money to return home, and the dilemmas a patient navigating such systems of care must face and negotiate. Next, I relate the shorter narratives of three patients who had already withdrawn from seeking care onto what I call *plateaus of tolerance*. My interlocutors recount impasses about whether their illnesses could be made sense of or not, whether their illnesses were exceptional, whether they could be delineated and addressed or transcended. At times, they seemed quite certain that their health was a "clinical question of physical…health" and, to a certain extent, could be restored. At others, these people reflected a notion that managing on with life-long, arbitrary physical debilities might be an aspect of learning to live life "within limits."

In conversation with affect and disability theorists, I end by considering the relationship between these plateaus and my interlocutors' notions of the sources and essential nature of

suffering in Kono. I return to *o, mɔtalman* as perhaps indexing a philosophy of life in Kono that resists peoples' relegation to states of "slow death."

David's Story

"I just saw *small small* blood in the urine," my research assistant, David told me in 2019, while I was in Kono for some months. He mentioned this in passing, as if it were just a feature of his aging body, triggered, he thought, by eating too much, but I encouraged him to go to the NGO clinic for some tests. A day of waiting in line offered a brief consultation with a low-cadre nurse, no diagnostic tests and a lunchbox-sized bag full of anti-parasite drugs of all types.

With the overwhelming patient loads, and the low cadre of nurse who were running the bulk of clinical work, the clinic had been seeming more like a pill-dispensary than a center for diagnostically-driven primary care. Sierra Leonean and expatriate doctors had told me that they were concerned about the number of drugs that were prescribed to every patient and that were not tied to any formalized diagnostic reasoning. But the nurses there had neither the training nor the time, and in any case, the consensus was that these antibiotic purges probably did not do a whole lot of harm since most patients were chronically infected with a range of parasites.

The blood in David's urine continued. He returned again and again to the clinic; at each visit (a whole day ordeal, with the lines and delays) he was seen for just a minute or two by a nurse, and given the same cocktail of antibiotics and antiparasitic pills. He was not inclined to question the nurses and was grateful for the free medications they offered, but I encouraged him to try the Government Hospital which Alliance for Health Justice was now supporting, and where he also had some connections with the staff. The lead physician there did an ultrasound and saw a small mass in the bladder. Someone there scribbled on a discharge note that David

should see a urologist and sent him home. I called a friend who was a physician in Kono and Freetown to find out if there were any urologists left in the country; one remained, it turned out, a very old man with a private clinic in Freetown.

David traveled to Freetown a few weeks later and paid the fee at the private clinic for a consultation. There, before David could get a word in, a trainee doctor ordered him with much bluster to go get a series of blood tests—for malaria, iron levels, liver function— at a lab across the city. "I must give it a go," David told me over the phone, while trying to raise the money for the blood tests he had already done in Kono. But when David returned to the clinic with the results the following week, he happened to be feeling ill and had a high fever. This more acute problem dominated that interaction with the urologist, and the junior doctor treated him for malaria. After three weeks of recovery, David returned again; the doctor asked for another ultrasound from a Freetown clinic and a CT scan—expensive procedures that required traveling to and paying a private hospital imaging service. But David obliged, as there was not much choice other than to follow the physician's instructions. David was not wealthy by any means—in fact, he often would tell me after the fact of the periods of hunger he faced throughout each year—but he and I contacted the various Americans he had met through the NGO over the years, and were able to raise funds for the imaging and care.

More tests, money spent, trips across the city, traffic jams, fleeting encounters with various labs and clinicians without any clarity of where resolution might lie or what it might look like. He was patient, tolerant, methodical: first things first, he just wanted to know what was even available in the country for a bladder tumor. But he was anxious about overstepping his role as patient, demanding or asserting too much from the intimidating physicians. At a certain point, David mentioned to the doctor that he had already been diagnosed with a bladder tumor in Kono,

had all the radiology films from the hospital there, and just wanted to know if this one urologist in the country had the capacity to remove it. The urologist responded that he was not interested in deferring to the "bush doctor out in Kono." David inquired, tentatively, about whether they even had the instruments to remove a bladder tumor at the clinic or whether he would need to start looking outside of the country for a hospital that could perform the procedure. The doctor laughed: "Let us decide what there is to do." David set off again for more tests.

Patients from Kono in need of complex care meet frustrations like this at every turn. Rich or poor, educated or uneducated, connected or not, resentments build. These failures are not always the result of terrible medical care—though the improvisatory arsenal of tests, pills, commands, diagnoses, explanations, formalities and intimidations offered at many clinics is nothing to romanticize—but also a product of the heart-breaking and arbitrary chaos of peri-urban life and migration in Sierra Leone. I had just left Sierra Leone when David, on the way back to the house where he was staying outside of Freetown while trying to get the attention of the urologist, was struck in the back by an SUV. Screaming on the ground, he tried to lift his leg up and saw his lower shin dangling, "that bone sticking out of the skin, blood spurting every direction." David's phone, money and ID card had all scattered on the ground, and some people nearby ran up to him lying on the ground and took everything. No bystanders came up to help. The SUV idled a few hundred feet away while those inside debated what to do. Eventually, the driver reversed to David, still lying on the ground, and threw him in the back. They sped off to the Chinese hospital nearby, but, David said, "due to the coronavirus situation, we couldn't meet any doctors there." The next morning, barely conscious, a nurse "stuffed the bone back in the skin," and someone arranged an ambulance to the main public hospital in Freetown where David was put in the emergency ward.

"I had to spend a whole month in the emergency ward," David recalled, even as those around him were admitted one by one into the medical ward, or died. "The smell of blood, the cockroaches, the rotting flesh—I have never seen anything like that." People died all around him, every day—and the shrieks of pain from his neighbors were relentless. From the US, I texted and called Sierra Leonean physicians I knew at the hospital to check on him. I arranged for NGO case managers to try and figure out why he had gotten stuck in the outermost ward of the hospital. Doctors promised they would come around; contacts said they could call a nurse who would pull some strings; medical students would briefly express sympathy on rounds. Nurses asked for tips to provide him extra attention; he provided them, but even garnering nurse-allies did not offer much beyond more regular bandage changes. All the while, David remained in the emergency ward. "Even though I had paid the money [for surgery]," he said, "for one reason or another the doctors always just used to try and [manually] set the bone." He told me later he suspected that a relative with whom he had never gotten along, who was a senior doctor at the hospital, had instructed the ward staff to refuse to bring him to the theater. "They would just have five strong men pull the leg and the doctor would try to reset it." Again and again, x-rays would show that the bone was not set properly and he would be sent back to lie in the trauma ward. The wound was shoddily wrapped and cleaned every few days by the nurses. No one offered a plan.

David found himself in a familiar position for patients from Kono: stuck for months on end in the hospital but without any clarity as to why or what comes next. Patients lie on old foam mattresses, watching a staticky TV in the corner of the room or just the passersby, receiving only vitamins and analgesics on the nurses' morning rounds. Little diagnostic scrutiny happens to these patients in Sierra Leone, where most of the available tests can be completed in a day. These

stays, at best, appear more routinized (to healthworkers and patients alike) as a kind of convalescence, a long respite after an accident or procedure in which not a whole lot is done by the healthworkers but the body rests. At worst, these months in hospital are a period of liminality during which many, many patients die of malnutrition, bed sores, simple infections, and disregard. “That time, I spent in the trauma ward, about seven people had to die in that ward,” he explained. “Any one that was fixed on any lifesaving machine or whatever ended up dying. So that was not easy for me.”

David was stuck. And unlike most patients who wind up in Connaught hospital, money was not the obstacle. He made it clear to the hospital staff that, with his network of American friends, an educated family and contacts in the diaspora, he would could raise the money for a doctor or nurse for more attention. He already spent hundreds of dollars on the imaging, tips for nurses and medical supplies. At a certain point, a relative suggested going to a the “native side,” a local bone setter in Kono. David was hesitant, but not entirely opposed to the idea. I was completely at a loss for how I could further help from afar or whether there was any purpose to him continuing to wait in the hospital, so I too thought there could be good reason to seek such local expertise—in the case of the leg, because local bone-setters certainly have significant experience aligning fractures, but also because it simply would be *easier* to put some faith in “the native side.” There is a kind of cognitive dissonance that is affected through this impenetrable disregard within the healthcare system. It’s not just that the nightmarish experiences lead to fatalism or giving-up or shifts in systems of care; even for those like David who are disinclined to leave the hospital, on long nights in the sweltering ward with nothing but one’s own thoughts, one comes to *want* the pain to be from something a healer can address—

even witchcraft— to *feel* that it is from witchcraft, because then an intervention would be so much easier to secure.

I spoke with David almost every day over the phone, and while he initially seemed patient with the process and resolved to have his leg mended, he began to slide into a deep cynicism. His focus in these conversations shifted from the trauma of his leg—his fear that he might lose the leg—to the broader injustices of the system, the contempt for the rural poor by nurses and other auxiliary staff and his conspiracies about his estranged relative masterminding the systems of exclusion. "You have no idea what these people will do here," he said. "Nobody comes by, they just don't care!" All this suffering, proximity to death, disregard by the hospital Big Men, unclear end-goals—was this because he was a person with a broken leg? A patient who happened to end up at the Connaught Emergency Ward? A Kono? A poor farmer deemed unworthy of care by the elite physicians there? What was his actual condition at this point? And was repair or bodily restoration even a possibility worth imagining?

David gave up. He left for Kono with a cast and crutch. At the hospital in Kono, physiotherapy staff tried to set the bone two more times. "I went through hell every time," he said, as they pulled and pulled on the broken leg, but still the bone was not aligned. Eventually, a doctor reviewed the x-ray after several weeks of David sitting at home, and said the leg was too far gone to be set at this point. Hopefully the bone had fused in such a way that the leg would be stable to stand on if David used a cane. All of the waiting in Freetown was for naught, and David would have to count on the body's capacity to have healed itself, always keeping in mind that one poorly-placed step could lead the leg to snap again.

Nine months after the accident, David returned to Freetown for a small procedure to remove a bone-shard embedded in the shin. While still in Freetown, I asked whether he should

go one last time to the urologist. The possibly-growing tumor in his bladder had been such a minor concern for the prior months, I knew that even putting this to the fore of his mind would be a point of stress. But this time, about a year after first visiting the clinic and without so much as a scan, the urologist said he could excise the tumor, not to worry and not to ask too many questions, this was an in-and-out deal. They'd likely be able to remove the growth with a scope, but if not could enter through the abdomen. "It was very strange—the guy actually treated me very, very nice!" David told me over the phone, with a resolve I had not heard for some time. "I think this doctor knows what he's doing."

The next week David went in early for the procedure. The cystoscopy machine didn't work, or so David assumed, for he woke up after an open bladder dissection in unimaginable pain attached to a catheter. He called me in the middle of the night. "I am in serious pain, man, even just breathing now I can feel serious pain." He said that as he was waking up from the anesthesia, the doctor mentioned to a nurse that they should give David morphine, but he had received nothing. "You know these people, here," he said over the phone. "She very well may have just gone off and sold the drug!" Someone wheeled David into a sweltering room in the back of the clinic with no medical staff and mentioned a 7-day admission. Nobody came to empty the catheter bag, nobody came to explain the outcome of the surgery, and when the urologist came for a brief check-up a few days later he expressed outrage at his staff's neglect, but still, nothing changed. Eventually, David was given two vials with samples of tumor tissue floating in them, and told to carry them to the private lab across town when he could to find out what exactly had been plaguing his bladder—and sent home.

Time Lost in the Pursuit of Care

The relatively positive ultimate outcome of David's trajectory through Kono and Freetown in search of treatment for his bladder— a long and painful recovery from the surgery, and a brusque and momentary assurance from the surgeon that everything was alright now with his bladder—was in large part due to the financial backing he had among American friends. But in our conversations over the phone that year, as he worked through and tried to maintain a resolve, we spoke a lot about how confusing it would be to live knowing there is a tumor slowly growing that, at any moment, could rear its head as a metastatic nightmare leading to a painful death. David certainly agreed, at least intellectually, with the desire to "take care of the health first." But it was his life to live, and he also wanted to go home to his family and farm. In a place where death remains a near-term possibility for most people from middle-age on, these conversations with David raised the question of not only how much money is worth investing, but how much time is worth spending in pursuit of care from systems that seem so (institutionally and interpersonally) uninterested in providing it. These dilemmas also unfold in the context of knowledge that one's ultimate return to domestic life—having achieved definitive treatment or not— will also be colored by ongoing physical struggle and uncertain futures.

There is a paradox about Sierra Leone's fragmented healthcare system: even with all of its material gaps, with sufficient funds it is rare that patients truly run out of options. There is always another mission clinic one could visit in the country, or coordinator to track down who knows something of when a European specialist team might arrive for a two-week "voluntourism" stint—one more week to spend in the trauma ward to pursue a final lead, or one last attempt at the private clinic of the one urologist in the country. Pursuing this elusive possibility of cure is a matter of money but also requires the conviction that the leg and the bladder could be healed—to have in mind a sense of what form such restoration would take.

David explained to me his own struggle to hold onto that possibility: “I always believed that, the man that gave me this leg –who, God or whatever— can still repair it.” So many months in a cast, sitting down, “most people would think that the thing will rot there, but I always believed that it would heal….I’m never going to expect it to be the way it was. As I get older, maybe some of the pains will start showing themselves. To me, that will be natural, so my mind will be prepared to deal with it.” David’s greatest challenge was resisting the overwhelming evidence that his condition was fundamentally that he was a poor Kono stuck in Connaught with a broken bone, a *mɔtalman we de sɔfa,*

The cruel irony was that, all that *fracas* and misery later, it was “the man who gave [him] the leg” who healed it. The fractured bone ends found each other and fused on their own. For many patients, the long periods of liminality in the hospital just lead to more illness, complications or nothing at all. For David, it afforded the time for uncoordinated, unanticipated but nonetheless real healing.

Part 2: Withdrawals

Fidel, a community healthworker in Mondu Fagbwe village, introduced me to Ramatulai, Sesay and George in 2012. Fidel was one of the former “traditional healers” that the NGO had hired to convince women and children to go to clinics for care as part of its efforts to complement the Sierra Leone Government’s Free Healthcare Initiative. While his mandate in this role was to focus on pregnant women and children, he had his finger on the pulse of who from the village was in the hospital, who was not feeling bright, where people had gone to look for care. Over time, as I shadowed him on his rounds, he introduced me to those from the village who he called

his "interesting patients." These patients were all adults who had withdrawn (in most cases, decades ago) to their homes with ongoing health conditions after fruitless searches for care. Our encounters with the interesting patients were fleeting compared to my real-time recording of David's travails, but I got to know these men and women over weeks and recorded their stories and hopes for what the future might hold.[44]

Ramatulai

By the time I met her in 2012, Ramatulai's right leg was swollen to the size of her entire trunk. We met her on the veranda of her concrete house, a small garden with flowers out front. The skin of the limb was taut and textured from what was clearly a massive amount of fluid collecting in her shin. Her toes, too, were enormous and looked melded together, each nail nearly cracking under the pressure in her leg. When Fidel introduced me to Ramatulai, I immediately thought of a sign less than a quarter mile from her house I had passed each time I traveled to the village which showed a crude painting of a woman whose condition resembled her own. Underneath the picture, it said: "For Free Big Foot Treatment (Elephantiasis), Visit The Government Hospital."

"I've been for treatment too many times," Ramatulai told me. "I went to the Koidu Government Hospital, but I got no success. I went to Magburuka, I got no success. So I came back and I started with this native treatment, but still no way."

It began with a fever, she said, and then she had trouble walking. "As soon as I went to the Government Hospital, the doctor told me that there was no treatment." The doctor there was friendly but said she would need an x-ray to figure out the problem. She followed his directive

[44] These interviews were initially conducted and collected as part of my undergraduate thesis research, in 2012, and included in the thesis.

and traveled all the way to the center of the country, to the nearest hospital with a working x-ray machine. She returned to Kono with the film, but still, she got no treatment. “I only spent a lot of money. So I have become tired. I decided to return. I went to these [local] medical, these native people.”

I asked her what the healers had told her. “Some said I got this problem from a friend.”

“Why would a friend do that?” I asked.

“I don't know the person.”

“Do you know why they'd do it?”

“As for me I don't know…I only know that it is a sickness.”

“Medical sickness or witchcraft?”

“Well, anyway, as for me, I don't know witch beliefs. Because, I'm not a witch. I don't even know what is a witch. So, I don't believe.” It seemed the question of etiology was no longer even on her mind. She had heard so many different explanations: something to be found with an x-ray; something from a friend; a witch. Now, she lived with this condition without making sense of it; it was just “sickness”.

“And, how does it feel now?” I asked. “Does it hurt? Can you move your toes, feel your toes?”

“Well, they are all heavy.”

“Is it getting any better?

“No.

“Is it getting worse?

“Yes. Every day it's getting worse. Even if I want to do some exercise in my garden, it's not easy.”

"But it doesn't hurt?"

"No."

I could not believe such gross swelling did not cause pain, but I also did not sense urgency in her tone. The condition could not have been comfortable, and yet she seemed to have settled into a kind of tolerance of it as a feature of her body that did not overdetermine her domestic life. Initially she had traveled all over the country for a cure, an effort that sounded as desperate and resolved as Jennifer's quest for Burkitt's lymphoma treatment, and as circuitous as David's efforts to get treatment for his bladder and then his leg. Now, Ramatulai just coped at home in a state of non-knowing what had caused the deformity—witch or no witch—nor what the future might hold. But maybe this not-knowing enabled her simply to go about her life without thinking about the turns it had taken. It was not that she was hope-less, nor resistant to pursuing further treatment. But she did not ask me if my connections to the NGO might help, nor if Fidel had any thoughts on further places to seek treatment. She beckoned us to look at the leg, but with a kind of shrug.

There should have been treatment for this condition. The signboard near her house, which said that she simply had to visit a hospital for free treatment, was put up as part of a massive private-public partnership to eliminate lymphatic filariasis from Africa. Since 1998, the pharmaceutical company GlaxoSmithKline (GSK) had supported the Global Alliance to Eliminate Lympahtic Filariasis (also known as elephantiasis) through its albendazole donation program. GSK even collaborated on this effort with its competitor Merck, which scaled up its Ivermectin donation program (since ivermectin and albendazole together can be used in elimination and treatment campaigns of elephantiasis) (Gustavsen, Bradley, and Wright 2009). Widely promoted as one of the boldest and most successful pharmaceutical industry

philanthropic programs—in that the two drug companies partnered to provide the drugs simultaneously and completely eradicate these "Neglected Tropical Diseases"—GlaxoSmithKline now claims to donate millions of doses of albendazole each year (Strahlman 2013) and Merck says it would sustain its commitment "to all who need it, for as long as it is needed" (Frazier 2013).

And here was a woman, her leg the size of a torso, just a few miles from the hospital where the signboard implored her to go. Maybe Merck-donated ivermectin and GlaxoSmithKline-donated albendazole actually were available there. I had seen many bottles of both at many other clinics in the region, and they were widely available at pharmacies too. But Ramatulai was resigned. It was "up to God," she said—the patient was not going to get to the drug. At least not before the pain became intolerable.

There was a heaviness to the way Ramatulai told her story. For years, it seemed, her life had been consumed with organizing, financing and traveling to clinics and healers across the country. Now, the leg did not wholly determine her situation. When she finished telling her story, she snapped out of the pathos and yelled loudly to the others in her bright, large house to finish cleaning the pots and pans littering the yard. Something had clearly shifted since returning home from her quest for care, no longer invested in nor guided by the notion that a resolution to her symptoms existed in some clinic or healer's compound. Now she was managing. It was not getting better, it was getting worse, but for now, the leg did not hurt.

Sesay

When we arrived at Sesay's house, his wife quietly pulled a set of chairs on the veranda. Sesay limped from the dark parlor outside, supported on one side by a crude crutch. As soon as I introduced myself and he sat down, he spoke without my prompting him, as if he was just waiting to tell his story."I got this problem by accident. A tree fell on me, when I was mining. When that happened, all beneath my waist, everything died. The doctors tried. This was in 1980." He was the leader of a gang of miners, working under a supporter in the swamps of Kono. "Back then I was a strong man. I was the one who was extracting the gravel, and I was standing under a tree. But there was a landslide, and [the tree] fell on me." He said he went to a private doctor and stayed at his clinic for over a month. Soon he could walk again. "I was a young man, the blood was flowing in my system and I never knew any pain—I was healthy!"

But in 2003, over 20 years later, he was "attacked with pain again….It came back, and I can't walk." He began searching for help again. "I went to [the NGO hospital at] Mabesseni Hospital, and they gave me medicine. I came back here, but still, there was no improvement." He tried healers for the disabling pain, "but I don't have much trust in them. They said it was pain. They said it was from that tree that fell on me. That there is dead blood in the system, and that's why I can't move my legs. That blood is not flowing." While the healers did not help with the condition, their explanation prompted Sesay to connect the recurrence of the pain to the accident so many years ago. Now, he narrated his life and the struggles therein as tied to that accident.

As he told me of his illness, he consistently wove the stories of his struggles to secure economic stability for himself and his family with this undulating pain. "From 1980-2003 nothing affected me," he said. "After that I didn't have any money again. It came back, and I can't walk….now I have so many children, so many wives, I have a compound, but I don't have money." The poverty and the illness were inextricable—which one preceded the other remained

unclear. But now, Sesay's story emphasized that the pain from the accident simply could not be delineated from the rest of his condition and thus life must go in within its limits. "Soon, [the pain] moved from the back to the leg, and I didn't have any money. No other money. That is why I'm sitting at home. I can't do anything for myself."

At times, Sesay did not seem to wholly buy the explanation that the landslide had caused this condition twenty years later. But, like Ramatulai, Sesay also did not hold close any particular notion of etiology. "I don't know why it came back now, only the doctors can prove it to me. Whatever doctor I get a chance to see will tell me the problem. But I don't have any money here, so I haven't been to a doctor [now]."

Sesay knew what he knew, and that was that his current condition extended beyond a pool of blood in his back. He ended his story with a kind of elliptical abstraction, a philosophizing about what it means to be a man in his condition in Kono, one that reminded me of the pathos conjured by the phrase *o, mɔtalman:*

> If you are a man, and you are strong, and you have a wife, and children, and a house, and you're not able to walk because the sickness has caught you, the women are still listening to you, the children are still relying on you. If you have been attacked by sickness, and if you have anybody who can help you, you will be so happy, too happy. But for now, whatever you've seen today, *that's it*.

George

George, an elderly man, was sitting alone on a cut tree stump in the back of his mud house, staring at a clothesline when I arrived with Fidel. The left half of his body drooped, his left leg was extended and his mouth frowned.

> The way I managed to get this sickness...I was feeling very tired. When I went to urinate, the color was different. The people said that it was yellow fever.
>
> It has taken a long time now since this happened. More than five years. When I walked and sat down, all of my leg hurt. I couldn't get up by myself unless people came to get me. I was taken to my bedroom; after a week, they took me to the Government Hospital, where I stayed for one month. After that I didn't see any improvement; it continues to this day. This foot is not active. They said it was a stroke.
>
> All the veins, the nervous system, are weak now. In fact if I want to go to urinate, if they don't come quick, I will wet myself. Even to defecate, I mess myself.
>
> I don't know what caused this problem. It's a disease, but I'm not a doctor so I cannot tell.
>
> I went to so many places for treatment, [and] so many native doctors. They need money, but they said they would treat me and I would be cured. They told me it is a stroke, that they have the medicine, but they need money. When anyone comes, they charge money. More than five places I have been to, but I have decided now to sit down and look up to God.

George's hand trembled as he spoke, but there was a mournful but content stability to the way he told his story. He had had a stroke, a singular event during which he lost the capacity to move on his left side. But I was struck by the fact that given this history of his current physical condition, the story he offered—not a life story, but a narrative of how he "managed to get this sickness"—stretched back to a time before the paralysis, to a time when he was "feeling very tired." He had spent a month in the hospital, a period I imagined as uncomfortable and with little given in the way of care. But he left, obviously, without a way of stringing together the signs and language of the clinicians. George had no clarity about what had happened and believed that the clinicians were at a loss about the cause, not limited in what they could offer. Now, his condition was referenced as "this problem." Had he been discharged, or had he withdrawn? From his perspective, it seemed the latter: "I didn't see any improvement." This was an agentive decision. "But I have decided now to sit down and look up to God."

Plateaus

In the rounds I made with Fidel to meet his interesting patients, I was reminded of my first weeks working in Kono's amputee camps documenting the amputees' narratives of war, injury, and life in its wake. These stories changed me and my assumptions about what happens (materially) in the wake of such a crisis, but also about the temporal structures of trauma and grief and the lives that are possible in such an aftermath. Each one of the amputees sat on his or her veranda and slowly, painstakingly related the horrific events leading up to and including their capture by the rebels. Each one told me, straight-faced, about watching their own family members killed in front of them, and then their amputations with rusty machetes. They described the years after the war, when all the journalists and researchers came and inquired about their stories. One NGO built them houses and another delivered monthly bags of rice. The government promised that the amputees would be supported for the rest of their lives with their disabilities and they were outfitted with crude prostheses. Over time, however, the houses began to crack and fall apart and one month the rice ceased being delivered; little came of the government social support packages. As the years went on, NGO mental health counseling programs lasted longer than the food-delivery initiatives, but eventually the amputees said they got tired of thinking and talking about the war so much. They had lost hope that any donor or NGO would help with that: many interviews ended with a shrug, a shaken head, and the line: *"Wi de sɔfa , wi de sɔfa, wi de sɔfa."* By the time I met them, not a single amputee regularly used the protheses and almost all begged in front of mosques and churches on Fridays and Sundays as their main source of income. They were bitter at their abandonment, but only in one community were they still organized into an

activist group. Though they told their stories with a lot of context—the fleeting humanitarian attention, the failed promises, the frustrations of the resources that combatants had been to "reintegrate" and how they had been left out of that process—they rarely made claims to an overt politics. "*We suffer, we suffer*." The amputees seemed largely to have plateaued in their expectations of the possibility for a restoration of anything close to their former lives and worlds. But many had restarted small farms on the outskirts of the camps and, as I spent day after day in their homes and villages, were adamant that the symptoms of post-trauma that so many counselors had imparted to them were not a great concern. They were not sleepless or easily-startled; they were tired from the exhausting work of maintain a house, gardening and begging with their debility. Their amputations did not physically hurt them so much as their backs and stomachs hurt from the hunger. My conversations with them again and again redirected attention from their war stories to their present lives, poverty and struggles for a better-than-now that they shared with many kin and neighbors. These stories "recast" the singularity of crisis into what Lauren Berlant calls a "zone of temporality…of ongoingness, getting by, and living on, where the structural inequalities are dispersed, the pacing of their experience intermittent" (Berlant 2007:759)? They had not accepted their lot, had not really given up on a better life, but made do alongside their kin and other villagers. At times, they almost seemed to be beckoning the question: how much had the amputations themselves actually altered their trajectories and life-chances?

A decade or so later, there were also common refrains, common structures to the stories of the Ebola survivors in Kono. After successfully organizing into advocacy groups and receiving international attention for their bravery and activism, the survivors had been promised free healthcare and a comprehensive package of social services with support from NGOs and

international donors. Some had traveled abroad to speak about their experiences and meeting Ebola survivors in other countries. Five years later, almost all of the aid and attention had wrapped up, and now they narrated their stories to me as they kept up with the activities of daily life—cooking, cleaning, taking care of the children and farming— with a quiet pathos. Things were tough, many breadwinners in the homes had died, they had learned not to put faith in promises of care or support, but still life went on. One Ebola survivor described the fleeting humanitarian attention as a predictable cycle, the way things work in Kono: *"People always forget quickly."*

Fidel's patients, like the survivors and the amputees, were not consumed with anger, they were not *resistant* to pursuing further services and care, they were not merely resigned—but their stoic affect seemed at odds with the stories they told of their prior trajectories in pursuit of justice, compensation or physical restoration. They now bore pain that was ever-present but also was not entirely unendurable. Illness— physical debility— was but one component of these patients' longings for a perpetually better-than-now future as the desired and ultimately elusive end to life trajectories; through the act of coping and continuing on, intractable conditions could, in fact, be shaped into something manageable.

Debility and the Ordinary

A definition of wellbeing premised on a clear delineation of sick versus well, disabled versus abled, infirmed versus healed, may, in the words of disability theorist Jasbir Puar, "reproduce neoliberalism's heightened demands for bodily capacity, even as this same neoliberalism marks

out populations for…the debilitating ongoingness of structural inequality and suffering" (Puar 2017:1). Vast swaths of the world's population in places like Kono, Puar argues, live lives characterized by ongoing, inescapable embodied structural violence. Among those existing in a state of what Lauren Berlant (2007) calls "slow death"—that is, the "physical wearing…and deterioration of people in that population" and a "mass physical attenuation under global/national regimes of capitalist structural subordination" (754)—the term "debility" and a frank reckoning with the "constitutive slow death of debility in terms of precarity and populations" (Puar 2017:16) is an important corrective to a field of global health that delineates and intervenes-upon specific patient-populations, conditions, states-of-health and crises. My interlocutors' stories speak to the transient and immaterial nature of the regimes of intervention that targeted amputees, the Ebola survivors, elephantiasis, maternal and child health, but also to a temporality and structure of these interventions that consistently efface their subjects' knowledges and experiences of broad bodily-deterioration being a fact of life in Kono.

Puar continues:

> The term "debility" can attach to the global south but can also be deployed in disenfranchised communities within global north locales to suggest debility as endemic, perhaps even normative, to disenfranchised communities: not nonnormative, not exceptional, not that which is to come or can be avoided, but a banal feature of quotidian existence that is already definitive of the precarity of that existence (16).

As Puar suggests, chronic pain, unexplained symptoms and illnesses, gradual disablement and deformation and a sense of the withering nature of bodies marked by impoverished agrarian life are part of the phenomenology of existence in rural Kono. There is an ordinariness to debility in Kono, a sense of it as a kind of sociality (think back to David's haunting evocation of misfortune and death as a kind of commons in Chapter 1) into which symptoms and injuries—a swollen leg, blood in the urine, even an amputation—can be enfolded. One can read these plateaus of

tolerance as people's own confrontation with an inescapable fate of slow death. The ordinariness of debility, perhaps paradoxically, may enable people to settle into a state of managing amidst irresolvable illness.

But the four stories recounted above also reveal a relationship to debility in Kono that is not, in Puar's worlds, "*already* definitive." Rather, David, Ramatulai, Sesay and George's appraisals of the nature of their debilities—whether their conditions were *exceptional* or *ordinary*, curable or facts-of-life—were negotiated through their traversals of systems of care, all of the horror, pain and desperation that involved, and their inevitable reckonings with the possibilities for restoration. Jennifer and Sia, for instance, emphatically resisted settling into the cancer as a fact-of-life, and maintained a frantic and desperate search for a resolution to the pain and for the girl's life until the very end. For David, holding close the sense that the "this leg… can still [be] repaired" was a struggle—a central preoccupation— during his months in sweltering trauma ward. In other words, people in Kono have not *already* "given up" on care, bodily restoration, nor lives rid of pain. Rather, these are the crucial dilemmas that patients face as they take stock of their bodies, the possibilities of care, but also, as Michael Jackson writes, come to articulate the "discontinuity between who [they] are and what [they] might become." The terms used by Berlant and Puar ("banality"; "activity of maintenance"; "just getting-by") at attune to the embodied effects of global regimes of inequality in places like Kono. But they must be qualified to reflect the internal turmoil and precarity of peoples' own confrontations with the stakes of their "physical attenuation under global/national regimes of capitalist structural subordination" as well as the creative forms of resistance and making-do that even the structurally vulnerable can muster. Amidst the relegation of the population to "mass physical

attenuation," ethnographic granularity and people's own storytelling consistently bring into view dynamisms that unsettle the deterministic terms of theory.

In this sense, I return here to the aside: *o, mɔtalman*. For this phrase indexes another theory of suffering and debility and a profoundly complex relationship to inescapable "slow death." *O, mɔtalman* offers a way of encountering such ubiquitous physical suffering without necessarily making sense of it, by allowing it to remain as at once alien, intolerable and arbitrary. When the bystanders stood back and watched the exploding tanker, muttering about the fate of man, when Ramatulai resisted certainties about whether her condition was a medical illness, a witch, or from a friend, this was not *normalizing* of the physical suffering. The suffering remained painfully in view, commented on, lamented. But at the same time the suffering was *felt* it was not necessarily made coherent or legible.[45]

There may yet be a kind of political posture here. As anthropologist Sarah Pinto writes of familiar scripts her interlocutors deploy to convey the experience of the loss of their infant children ("everything is in the hands of God." "Sometimes babies just die like this." "Sometimes this is what fate hands us"): "The realities of life for the rural poor put lived causality at odds with the rational-technical language of certainty." But, Pinto insists, this is not a subjectivity of numbness, fatalism, nor an acquiescence to the banality of death. "In being left unresolved, the dead child and the child's death are indices of the overwhelming conditions of

[45] Cameroonian scholar Celestin Monga, likewise, urges us to take seriously the nihilism that he argues is the vernacular philosophy of urban West Africa. This is a nihilism born of collective and clear recognition of the absurdity and violence of everyday life in the postcolony, one that actually enables forms of joy, humor, irony and flourishing rather than just immiseration. "On this basis, many of my Cameroonian compatriots and millions of other African citizens across the planet feel contempt for all transcendence," he writes. "They celebrate the meaninglessness of existence and participate with remarkable talent and creativity in the construction of this 'active nihilism'" (Monga 2016:31–32). And so perhaps, in not assigning meaning to debility, in refusing to fixate on its *name,* these patients refused to allow it to overdetermine their lives.

everyday life. Rather than normalizing loss, it is as though [the women] say, '*Look at what is normal*'" (Pinto 2008:374, my emphasis).

The silence in the space of meaning, the refusal to name a leg with elephantiasis something more than the word "sick," the tolerance of these conditions while making-do peeled off from the promises and hopes of care—this all may similarly emanate outward. The disappointments of care, in the context of the conditions of everyday life and the illusory claims and injunctions of regimes of global health, beckoned patients like David, George and Ramatulai to turn something like an ethnographic eye to their own ailments. They sensed that these illnesses fundamentally emanated from the yet-unspoken social—political, historical, economic, structural—determinants of health. At the same time, that burgeoning recognition that ultimately it *was* the poverty, not the tree that fell down, the parasite blocking a lymph channel that could be killed with a pill, the broken bone, certainly not their lack of *desire* for "taking-up" care—precluded the possibility of a patient like Ramatulai believing that her illnesses could, at this point, be resolved. The exclusion from the healthcare system further affirmed an existential reading of her own bodily debility; she had done everything right as a patient and still her lot was debility. The debility, in the end, could not be made sense of nor delineated as a problem to be "fixed." As Sesay said: "I have decided now to sit down and look up to God."

O mɔtalman is an existentialism of suffering in Kono. Repeated again and again, this phrase does not affirm a normalcy to debility, but rather insists upon the illegibility of the suffering—the sense that it could not be meaningful or anything beyond arbitrary, for this might be simply too disorienting to carry on. Think, for instance, of the abjection sedimented by the European doctors telling Sia that Jennifer's sickness in fact had a name, but would not be treated. *O, mɔtalman*, alternately, is a philosophy of how to persist with an abeyance of deep meaning-

making amidst structural violence that feels—and is thus stated to be— intractable, inevitable, nonsensical.

And so Ramatulai, a woman with a tree-trunk sized leg, continued to live in the shadows of a poster that proclaimed: “For Free Big Foot Treatment Visit The Government Hospital.” She had gone to that very hospital so many times, but she got no treatment and eventually became “tired.” Tolerance, underneath lamentation, may indeed be the radical possibility for life in these conditions.

Chapter 4: Seen but not Meant

One evening, as I sat with David at a cookery shack on Lumley beach, he began to tell me of the day that British soldiers landed to secure Aberdeen as a safe-zone from the combatants surrounding Freetown. Now the center of Freetown's elite social scene, a collection of gaudy Chinese and Lebanese businesses on one side of the street and hastily built stick bars on the other, it was hard to imagine what David described. "The spectacle, you wouldn't believe it," he said, pointing up and down the beach. "The way the British troopers came down from the choppers with ropes, they were hovering here and there, pulled out in little boats from the waves." Thousands of Sierra Leoneans, who had lived through sporadic violence for the past decade, stood in a half circle at the top of the beach where scrubby grass littered with plastic bottles met the sand. I imagined the scene he described: British military helicopters hovered above the beach, aquatic vehicles crashed through the waves, commandos swam to shore with automatic rifles, scoping left and right. But there were no rebels to be found, only a crowd of curious spectators.

David was lost in thought. I asked: "People must have been excited that the intervention would mean the end of the war, right?"

With his eyes were closed, also remembering the scene, David shrugged and shook his head. "Ehhhhhh…maybe?"

"But why did the people watching think that the British had finally decided to intervene?"

He took a drag on his joint, nodding his head to the memories and to the beat of the pulsing reggae coming from nearby. This was a question that I had pondered for years. South African mercenaries and Nigerian troops, UN Blue Helmets from Nepal and the Gurkha Rifles, Mende militias and Ukrainians had all led promising military interventions into the country over

the prior eleven years. But none of these campaigns had restored the country to stability before the foreign troops had withdrawn.. Three peace agreements had failed to stop the sporadic violence from resurging. In 1999, the British had backed the Lomé peace accord, which offered rebel-leader Foday Sankoh pardon in return for a cease-fire agreement. But this agreement also soon fell apart as other rebel factions refused to disarm, and various combatant groups surrounded Freetown. The UN peacekeepers began a total evacuation from the country. Ex-patriates, again, began to assemble at the Mammy Yoko hotel in Aberdeen which would serve as an evacuation hub.[46] A few days later, the British military launched Operation Palliser and began evacuating British civilians.

Several days into the operation, British journalist Richard Dowden wrote in the Guardian: "Are the troops there to protect some vital British interest? The once-rich diamond areas are now commercially ruined by freelance diggers. We no longer need the naval base. Sadly, Sierra Leoneans have nothing to induce Britain to send troops there except their imperiled humanity." Still, he maintained, it had to be done. "if Britain left Sierra Leone now and the people of Freetown were butchered the UN might as well close down and the world accept that it is two, not one. The line is drawn on that red gravel road from Aberdeen" (Dowden 2000).

It always struck me as so arbitrary: for eleven years the country had been embroiled in smoldering violence against civilians, coups and counter-coups, slave-labor in the diamond mines, amputations and sexual violence—and then in early May 2000, about 5,000 British soldiers ended it all, bolstered the UN mission, and within a matter of months the country was disarmed and at peace. What threshold was crossed?[47] Anthropologists have written much about

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[46] This hotel served at the time as the UN Mission headquarters. It would fall into disrepair after the war, but would be rapidly stored as the Radisson Blu in the early 2010s and would serve as the hub for all expatriates involved in the Ebola response in 2014.

[47] For a discussion of some of the non-humanitarian rationales for the British intervention see Williams 2001.

the impetuses of humanitarian interventions, often driven more by donors' inconsistent and mixed affect (like that conveyed by Dowden) than a coherent politics (Fassin 2011; Ticktin 2017). But how could people whose lives were at stake make sense of this—particularly as they lived and made-do with the proximity to death by war, and, in the wake of the conflict, told their own histories of how things ended?

I pushed David again: what exactly did *he*, did the people watching as the commandos landed, think had prompted the British after so many years to intervene?

He first responded first that it was "no surprise" that the British tried to make Aberdeen the first safe zone; that was where all the UN workers and the expatriates and the wealthy people lived. "And I just think," he went on, "after watching us kill each other for some time they just decided that enough is enough." The stakes of his own life, the fact that this intervention may have *saved* his life (David had had several close run-ins with combatants), did not factor into his recollection of what seemed to me a seminal moment in the country's history.

He returned to describing everyone at the beach watching what was unfolding, the spectacle of it all, with a sort of pleasure and detached amusement, as if the scenes they had watched in grainy pirated Hollywood war movies were now being projected in front of them. "It was like people were more interested in what they were seeing," he added, "than what it meant."

When I think back to the descriptions I have heard from colleagues, interlocutors, local historians and friends of the various factions that entered the country during the war, these narratives too convey a similar affective distance and suspension of deep meaning-making. People observed and now relate the amusing, frightening and peculiar features of the soldiers who came and went as a type of entertaining ethnological exercise. The Nigerians were brutal, killed as many children as the rebels and ate many dogs. The South African mercenaries were

fearful black men in helicopters who took diamonds. The Pakistani soldiers had many pet chimpanzees. The Bangladesh people spoke in a funny way. None inspired particular confidence—save, perhaps, the few who Kono friends remember as trying, in the refugee camps or hospitals, to help the injured. David's cynical rendering was as close to an articulated motive for the foreign interventions I had ever heard: the British just "decided enough is enough." Humanitarian reason may be a politics of life, but this incursion was not born out of any real valuation of his own life as a Sierra Leonean. It was, in his view, just "embarrassment" at what Sierra Leoneans had been doing to each other, at the abjection of it all. One day in Freetown, which was filled with the threat of violence and tension like so many before it, British troopers repelled from the sky. And that was that.

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When I returned to the United States in December 2019, I tried to find videos or photographs of the British invasion of Aberdeen beach. On Twitter, I found some grainy pictures of the special forces repelling down ropes from helicopters (Harry Boone 2020; The Other Chris 2018). But there were many debates on the Twitter thread. Was this Operation Palliser, the initial intervention, or Operation Silkman, a subsequent training and stabilization campaign? In a (now-deleted Twitter thread) a military expert who seemed to have been there at the time insisted that this was not the *true* landing on Aberdeen, just a demonstration of force with lots of locals watching. David told me more disturbing memories from that day that suggested that even the participants in the invasion undermined the façade of a high-stakes mission. After landing, the British soldiers, David said, had tried to rally the Sierra Leoneans watching. "'The war is ending,

the war is ending,' they kept saying to us. But I even saw it with my own eyes, some of the British soldiers took their dicks out and were showing them to the girls on the beach, yelling: 'The war is ending!'"

I did more research. The Royal Air Force noted that their own involvement was "part of a series of military demonstrations that were carried out by the British military to demonstrate the UK's commitment to the Sierra Leone Government and to reassure the people of Sierra Leone" (Royal Air Force 2021).. A press release published in 2000 in a Sierra Leonean newspaper under the headline "Royal Marines Came Ashore in Sierra Leone" said that: "the [British] Government made it clear that, under our memorandum with the United Nations, we were ready to deploy a rapid reaction force in support of UN peacekeeping operations, including that in Sierra Leone. Today's exercise was a highly visible demonstration of the seriousness of that commitment" (UK Joint Task Force Headquarters 2000). David's ambiguous rendering of that event—*ohhhh the spectacle*—was in fact the most apropos: the historians and soldiers involved could not even remember if they were acting or invading.

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In 2014, at the height of the Ebola outbreak, the same Sierra Leonean newspaper that had covered the invasion of Aberdeen beach ran an almost identical headline: "Royal Marines Go Ashore in Sierra Leone." A team of marines attached to a British hospital ship that had been sent to assist with the Ebola situation headed across the bay from Aberdeen to one of the hardest hit regions, where Ebola had already killed thousands. Photographs show several zodiac crafts filled

with camouflaged men landing on the sand among the waves, as dozens of Sierra Leonean children and adults watch, many with large baskets of market goods on their heads.

The marines arrived in order to conduct sonar surveys of the beach to assess its "suitability for landing"—landing what, exactly, it is not clear from the article. There are photos of the villagers helping the marines drag the boats on shore, and the Sergeant in command noted that some people offered their local knowledge to help with the surveys. But most of the local people in the photographs seem to be standing back with amused and impassive postures as inflatable military rafts filled with camouflaged white men inside emerged out of the waves and onto their village's beach.

Fourteen years after the scene that David had described, the resemblance to the image he described is uncanny: a half-circle of Sierra Leoneans stood at the top of the beach watching the spectacle unfold in front of them. The British Sergeant leading the marines seemed almost surprised at this reception. "'The reception we received was overwhelming; I'd say that more than 150 people met us when we landed on the beach... and despite Ebola being a major issue in West Africa,"—and here, his words reference both the virus and a humanitarian juggernaut, including British zodiac rafts crashing to the shores of a coastal village unannounced—"it seems that life is continuing as normal" (Cocorioko 2014).

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David recounted his memories of the invasion of Aberdeen beach some three years after the last Ebola case in Sierra Leone. But I kept thinking it over, that curious way in which he described how he, and the others at the beach, assembled as if an audience to the humanitarian invasion. David had told me all this in retrospect—in the intervening time, there had been multiple

humanitarian emergencies that brought similarly brief waves of expatriates and resources and technologies to Sierra Leone's shores, before they retreated— and maybe this colored the way he recounted the scene that day. But his story affirmed, to some extent, an uneasy sense I had had throughout the epidemic of being a participant in a humanitarian juggernaut that had, amidst the high-stakes of Ebola and the paradigms and aesthetics of emergency, peeled off from the objects and telos of an epidemic response: tracing, isolating, caring for patients; figuring out how to navigate social complexities and dynamics; managing the logistics to support both efforts and halt transmission.

The international Ebola response seemed so utterly laden with excess. Why were there so many military helicopters flying around and around overhead, I remember thinking at the time, which often just seemed to be "patrolling," rather than delivering supplies or blood samples? What had the British sent *so many* troops, when the soldiers were so limited in what they were skilled or allowed to do and just seemed to drive around a lot, 'escorting' undefined things, in military vehicles? Why did the hundreds of white, expatriate clinicians and logisticians insist on wearing safari vests with so many pockets and the institution they represented labeled in English and French— as if they would not be recognizable in Sierra Leone as foreigners without such costumes? Why did the new fleets of NGO Land Cruisers have "no machine gun" stickers plastered on all the windows, as if this operation was all taking place in a war zone? Why did the conversations with "social mobilization" experts so quickly morph into technocratic and jargon-filled language of how to "target superspreaders"? Why did the CDC workers make such a show of opening their metal briefcases with toughbooks inside and what seemed like dozens of antennas erupting out of them, when all they needed was an Excel spreadsheet to keep track of case counts?

Perhaps there were expert logics underlying each of these manifestations of spectacle. Maybe the Red Cross clinicians needed dozens of pockets; maybe the development office of MSF had learned that taking photographs of muddy Land Rovers with "no machine gun signs" triggered increased flows of donor affect and generosity born of their sense that these "Doctors Without Borders" operate under conditions of extreme danger. Maybe there was a similar kind of economic inertia among the other organizations: the semblances of danger, emergency and the scripts of militarized incursion brought about the funds that could usher in even more logisticians, Land Rovers and vested Europeans.[48]

However, other kinds of affect seemed at play here too, the pleasure and intensity that comes from role-play and dramaturgy. There was that sense of *bêtise*—that "assertive" but not necessarily fleshed-out arrogance that Guillaume Lachenal argues has propelled so much of the history of public health in Africa. But the paradigm shift in Sierra Leone among the humanitarians, from the vacuity of routine public health programs to epidemic emergency, had also inspired a pivot (again, borrowing from Lachenal) to "regimes of *fictive* interventions" (Lachenal 2015): an epidemic response in real life mimicked scenes from *Contagion*, rather than the other way around.

And so, perhaps those at Aberdeen beach in 2000 "were more interested in what they were seeing than what it meant" because the spectacle of it all obfuscates, again and again, what

[48] Of course, one of the reasons there was so much hustle-and-bustle among the Europeans and Americans was that a part their mission was to protect and serve their own countries, their own compatriots, to keep the disease in Sierra Leone and from spreading abroad. This was made very visible to all: the British military-run Ebola Treatment Unit with a modern intensive care unit inside, that was initially reserved only for foreign healthworkers who contracted the virus, abutted an NGO's "no-touch" Ebola Treatment Unit for Sierra Leoneans in which foreign clinicians were prohibited from even touching the patients inside. This further made concrete the gap between the humanitarian's bodies and the Sierra Leonean's own, with life-or-death stakes.

"it" all "means". And in 2014, as the epidemic responders played at acting out an outbreak movie; the Sierra Leoneans once again watched with detached, skeptical but amused fascination.

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In this chapter, I want to explore the nature of the space between spectator and spectacle in moments of humanitarian crisis in Sierra Leone. How does a humanitarian incursion during a time of war or Ebola, a juggernaut that no doubt does bring resources that can make or break real people's life-chances, come to *feel* like it is occurring at a distance? What is the difference between, following David's own evocation, a subject of humanitarian care being interested in "seeing" the humanitarian juggernaut, versus being interested in "what it means"?

In the prior chapters, I have considered how colonial history and extraction, the neoliberalization of global public health, its relentless focus on vacuous behavior change mandates, the "gatekeeper politics" of NGO-State relations and the repetition of global health para-institutions may affect a relationship of skepticism towards care. In this chapter, I particularly focus on forms of political authority within Sierra Leone, to ask: what are the landscapes of contemporary local politics that, when entangled with these waves of spectacular and temporally-bound humanitarian incursion, engender a collective disposition of *spectatorship?* How do the *subjects* of serial humanitarian incursions also come to inhabit space—to *propriocept*— as *witnesses*? The facets of history, geopolitics and regimes of global health considered in the other chapters of course also play roles in the conjuring of spectacle during a moment of crisis like the 2014-2016 Ebola epidemic. But here my interest is in how postcolonial African theory— and an attention to what Charles Piot calls a landscape of West

African politics "wired for dramaturgy" (Piot 2010:19; also Comaroff and Comaroff 1999)—may offer different ways of capturing people's ambivalent relationships to epidemics and regimes of care.

After a brief introduction to ways of conceptualizing postcolonial West African political power and its relation to spectacle, I recount three discrete moments of tension which demonstrate the growing sense of nervousness and eruption in Kono through the epidemic. "Spectacle" serves as the through-line in this sections, as I aim to trace how three different experiences or social domains intersect in dialogue with each other in moments of humanitarian crisis: the fleeting, seemingly arbitrary but also somewhat interminable presence of what I call the humanitarian juggernaut; an immanent landscape of politics in which political authority within Sierra Leone does not align neatly with conventional notions of biopolitics and is experienced by rural people in Kono as a field of spectacle; an ongoingness to people's sense of vulnerability to epidemic threats, violence and death. This is not to discount the centrality of other social and structural dynamics that structured the Ebola epidemic and response to it, of which much has been written—the expert logics of humanitarian intervention, the material consequences of Sierra Leone's underdeveloped health system, the "rationality" underscoring peoples' aversion to an Ebola response apparatus that often endangered people who did not have Ebola and, for those who did contract the virus, offered little in the way of care (Benton 2014; Frankfurter 2014; Benton and Dionne 2015; Richardson et al. 2016; Richardson et al. 2017; Abramowitz 2017; Farmer 2020).

But an attention here to spectacle in addition to these other forces may open up new ways of considering the mixed feelings and ambiguous actions engendered through individual people's encounters with the public health response. I then end the chapter by returning to the stories of a

group of Ebola survivors in a “hot-spot” village, to explore the affects of living and dying that went on “beneath” the spectacle.

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“The nation-state sees the entire territory as its performance area; it organizes the space as a huge enclosure, with definite places of entrance and exit,” Gikuyu novelist and theorist Ngũgĩ wa Thiong'o writes of the postcolonial African political condition.[49] “The nation-state performs its own being relentlessly, through its daily exercise of power over the exits and entrances, by means of passports, visas, and flag.” Thi’ongo later suggests that postcolonial African space today might best be envisioned as a prison: “for even in a country where there are no military regimes, the vast majority of people can be described as being condemned to conditions of perpetual physical, social and psychic confinement.” The prison, in turn, might be thought of as a stage, since “everything, including movement, is directed and choreographed by the state.” Postcolony, prison, stage: within the borders of this space, the state performs, again and again, “its rituals of power.”

Theories of “performativity” dominate scholarship on contemporary African political formations, subjectivity and life. Why this shared “historical trajectory” (even with all of its divergences)—"that of societies recently emerging from the experience of colonisation and the violence which the colonial relationship involves" –has led to this collective centrality of spectacle, “a distinctive style of political improvisation, by a tendency to excess and lack of proportion” (Mbembe, 102) is not entirely unclear. We have all seen the photos of the

[49] In this article, he oscillates between talking about contemporary statecraft broadly, and postcolonial African condition. I take this section to be about the latter.

postcolonial African dictators and their mansions, read about the grotesque, almost whimsical forms of violence enacted on and among citizens on the continent, the "presidential grandiosity, political sycophancy, ostentatious corruption, flamboyant violence, and coercive ceremonialism" (Karlström 2003:58). In Sierra Leone today, people argue, fight and even die and kill on behalf of the two primary political parties, parties that are essentially two extended patronage networks, with no discernable differences in ideology, strategy or articulated platforms. Political support derives from the resources (cash and infrastructural) that are distributed to supportive populations along ethnolinguistic and geographical lines, and the aesthetics and mystique conjured by candidates' charisma: the stern-faced photographs of the leadership plastered on walls and posters, the displays of military might in the form of armed convoys tearing through town and gangs of young men co-opted as security, the mottos repeated in fierce arguments in tea shops around the country. (The current President's: TOK AND DU; *BY ANY MEANS NECESSARY.)*[50]

African literary and postcolonial theorists have moved away from analyzing this register of spectacle within postcolonial African politics as grounded in discernable *ideology* or *rationality*. Cameroonian historian and theorist Achille Mbembe, for instance, addresses postcolonial political subjectivity via what he calls the "aesthetics and stylistics of power" at play. Postcoloniality and contemporary West African politics, for Mbembe, is a field of signifiers, affects, fervors, humors and collective dispositions, not policy-platforms or ideologies,

[50] Anthropologists have offered explanations for this political order of spectacle, drawing on various intellectual traditions in the field. The Comaroffs write that it is, "a vital part of the effort to produce social order and to arrive at persuasive ways of representing it, thereby to construct a minimally coherent world-in-place," (292). Others seem to shy away from positing outright that African politics adhere to a different regime or logic of power than Euro-American sovereign authority, and try to locate the internal or legible "coherence" or impetus for all of the spectacle. Charles Piot, for instance, offers a more materialist argument: in the context of the neoliberal undermining of state authority and resources, "a withered [African] state…has to 'perform' itself to convince its subjects that it remains powerful" (Piot 2010b:19).

and cannot be reduced to *logos.* Colonialism, he writes, imparted a particular familiarity with the arbitrary, the nonsensical but still material: "The lack of justice of the means, and the lack of legitimacy of the ends, conspired to allow an arbitrariness and intrinsic unconditionality that may be said to have been the distinctive feature of colonial sovereignty." And this is how this historical condition has continued to play out its legacy: "Postcolonial state forms have inherited this unconditionality and the regime of impunity that was its corollary."

Central to this unconditionality is what Mbembe calls *commandement,* a term that encapsulates the notion of sovereign power that animated colonial rule and autocratic postcolonial rule alike. *Commandment* included the "weakness of, and inflation of, the notion of right: weakness of right in that, in the relations of power and authority, the colonial model was, in both theory and practice, the exact opposite of the liberal model of debate and discussion: inflation of right in that, except when deployed in the form of arbitrariness and the right of conquest, the very concept of right often stood revealed as a void" (25). These relationships to the unconditionality and intrinsic nature of political authority, in tandem with the violence enacted by the colonial state, accreted as "the central cultural imaginary that the state shared with society" and that, in many ways, has endured to this day. The dialogics of power and spectacle at play between citizenry and political leaders in the African postcolony cannot be reduced poles of "oppression" on the part of the state and "resistance" on the part of the masses. Rather, the two sides of political power are more entangled, in a relationship of what Mbembe calls "convivial tension": regimes of autocratic authority and spectacular violence are made quotidian, hegemonic, and come to constitute "repertoires" of action shared across political domains. After all, as Mbembe writes, one of the most distinctive features of postcolonial Africa is how "the subjects of the *commandement* have internalized authoritarian epistemology to the point where

they reproduce it themselves in all the minor circumstances of daily life." It is difficult to imagine true political overhaul or transformation in the wake of this history. Rather, as Mbembe writes, the postcolonial political and economic collapse on the continent has "pav[ed] the way not for some sort of revolution but for a situation of extreme material scarcity, uncertainty, and inertia" (24).

Today, the West African postcolony is the staging ground for another form of spectacular, unconditional politics (of which Mbembe does not write): global humanitarian interventions. These waves of international concern, life-sustaining resources, personnel and technologies, such as the massive international effort that materialized in Sierra Leone during the Ebola outbreak, are often analyzed, and critiqued, by anthropologists as driven by regimes of (Global North) expert logics. "Militarization" (Benton 2014); "containment over care" (Farmer 2020); "humanitarian reason" (Fassin 2011); "securitization." But the aesthetics of humanitarian intervention—the excess, the affect, the arbitrariness, the spectacle of the pocketed vests, the helicopters, the undefined-invasions-or-demonstrations—also become entangled with and enfolded into that of postcolonial *commandment*.

When I speak with people in Kono today about *Ebola-tɛm* [Ebola times], they do not often emphasize a sense of panic or even of personal crisis. No doubt, the Ebola survivors recall this period as when they hung close to death for weeks on end in sweltering treatment units, and when whole swaths of families disappeared and died and with them life-sustaining income. But those who just lived in proximity to the disease now speak of it more as the escalation of the ongoing challenges of postcolonial politics, life and care, as political leaders expressed indifference to the plight of impoverished people followed by sudden, spectacular and seemingly-arbitrary intrusions into their lives.

In 2014, Ebola checkpoints manned by soldiers and police dotted the roads through and out of town and on the highways into the hinterlands. But the scenes at these checkpoints recalled the police stops that have always punctuated Sierra Leone's highways—in the same places, in fact, that they had first been erected during the war and maintained through to the Ebola crisis. Stacked logs blocked the roads and skull-and-crossbones signs hung from tires. The roles were not clearly delineated among the individual officers who seemed to work together well in their efforts to extort. A confusing amalgam of police, military police and heavily-armed soldiers scoured the trunks of *poda podas* in ways that made as little sense as the roadblocks that now frustrate and extort travelers today—what were they looking for? Those staffing the checkpoints often wore a hodgepodge of PPE: a pair of gloves, one gown, a face-shield, rubber boots or a surgical mask. Big Men and NGO workers were given "inter-district Ebola passes" to show at these checkpoints, a laminated card that said "Ebola Response" typed out in dripping-red, Zombie-movie style font.

The police enforced lockdowns on restaurants and businesses in the early evening by detaining and extorting anyone returning home after curfew time, but left the "goat pepper soup" place frequented by the Sierra Leonean NGO workers and other Big Men open as a vibrant speakeasy. The President mandated all markets and even supermarkets closed on Sunday as a result of the "State of Emergency", an order that, for some reason, was never lifted and remains in effect to this day, which seems to undermine whatever justification was officially used in the State-of-Emergency announcements back in 2014.

Today, interlocutors in Kono make jokes about the excesses of political leaders' tastes and their dependency on crises for donor dollars—*of course* the now-ruling Sierra Leone People's Party President is going to make a big spectacle out of COVID-19, it's about time the

new government got a chance at its own Ebola when the donor spigots flowed!" Others point out sarcastically the buildings, hotels and businesses that went up quickly in 2015, when there was so much cash flowing through the NGOs that everyone knew staff could siphon off tens of thousands of dollars without fear of consequence. They laugh uproariously when recalling the week that the US State Department announced that several American NGOs had rented compounds from a Hezbollah financier, and scurried to find other multi-story buildings and hotels to lease. The topic often takes on a tenor of discussing national political intrigue and conspiracy: How did the Lebanese man reconstructing the Radisson Blu time his renovations so perfectly to ensure all the rich white people would be able to stay there? Did he *know* Ebola was coming?

Those living in Koidu today speak with some awe at the military power that enforced these new concepts and technologies of epidemic containment—*quarantine, travel ban, temperature screening, lockdown*. But at other times, in conversation, the façade of reverence bursts. The President's most exalted intervention—a "3-day lockdown"—teams of healthworkers did supposedly scour every house for sick people and bodies, but what could this actually accomplish if Ebola takes 7 to 21 days to incubate? And what really were the police looking for when they pulled everyone out of public transport vehicles and tore up the trunk? Sometimes, at the end of recounting their memories from *Ebolatem*, people in Kono point out that all the spectacle just amounted to more opportunities for agents of the state to extort ordinary Sierra Leoneans trying to go about their days and keep from getting sick amidst an economic collapse and restrictions on their movement.

"*Sɛns. Nɔ. De,"* people in Kono say [no sense to it]. It all seems like a story or fable sometimes. There is a deep but all-knowing cynicism conveyed in these recollections that such

widespread illness brought so many dollars to the country, that those at the helm of the country's "politics of the belly" (Bayart 2009) would inevitably make out well while ordinary people would face capricious illness and death, and that throughout, spectacles of state, NGO and military power would stand-in for more substantial forms of care. It was a terrifying time, it was a tragic time, it was a brutal time—but day-to-day life was also colored by the absurd, in ways that merely escalated the ongoing farcicalities and arbitrariness of life and politics in the Sierra Leone Postcolony.

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In early April 2014, I was in Kono when the District Medical Officer called to tell me that the first Ebola patient may have been brought to Kono District. For several weeks, Ebola had been spreading through a neighboring region of Guinea, but life had gone on in its relative normalcy in Kono. As always, we assembled as a para-institution in the dusty conference room of the District Health Management Team.[51] The Paramount Chiefs were all there, as were the other NGO-bureaucrats (myself included). Someone from the Guinean Ministry of Health, we were told, had notified the Sierra Leonean Ministry of Health that contacts of an Ebola patient had traveled across the border. The Ministry of Health was not sure what district the village was

[51] The New York Times published a major expose of the failings in communication between the WHO, and the Guinean and Sierra Leonean Ministries of Health when Ebola patients were tracked into Sierra Leone earlier on in the outbreak, potentially leading the disease to spread uncontrolled and unsurveilled for months. While they quote sources saying that the Guinean health officials tried to communicate with Sierra Leonean counterparts, but that the information was never pursued, I have wondered whether this first meeting I attended was actually the follow-up, unfolding in a vacuum of institutional support or expertise. If so, the fact that there is complete institutional amnesia of the follow-up is itself revealing of the ways these epidemic contingencies unfold in rural peripheries and para-institutional formations (Sack et al. 2014).

in, but notified the Kono District Health Management Team who sent a team to investigate at a town that had a similar-sounding name. Indeed, we were told, there were stories of a family who had traveled from Guinea. They had all died.

There was little formal expertise in the room, and we had each been given a print-out of the Wikipedia page for Ebola to draw from in our plans for a preventative response. "I want to see hundreds of volunteers going door to door to get the word out," suggested one person.

Someone else added: "We need a budget for a jingle!"

"Engage the artists and motorbike riders!"

"And market women!"

"We should make every Guinean in the district register with local Government, and be ready to expel them if the disease spreads!"

In the room, we recapitulated the strategies of behavior change and health outreach past. Women should be directed to deliver in clinics; mothers should be told to make their children sleep under mosquito nets; locals must learn rudimentary hygienic practices, stop eating bushmeat, and cooperate with local health regulations to slow the spread of Ebola; *massive, mass-ive sensitization!* We all knew the limits of local healthworkers' capacity to deal with what would inevitably come. There was no protective equipment in store, and nobody had any training in Ebola infection prevention. In some ways, to borrow from John and Jean Comaroff (Comaroff and Comaroff 2006), this first meeting was a postcolonial "simulacrum of governance, a rite staged to make actual and authoritative, at least in the eyes of an executive bureaucracy, the activity of those responsible for law and order" (289). As Baudrillard points out (1994), a simulacrum conceals the *absence* of the real—in some ways, there was no *there, there* in that first meeting in Kono— and yet still, one draws on what one has available amidst contingencies

that exceed the resources at hand: in this case, the archive of behavioral public health interventions that had saturated the region over the past two decades. Someone volunteered to write the budget for jingles, bicycles, workshops and radio messages that would be forwarded on to "the donors."

The Paramount Chiefs' contributions, however, somewhat changed the tenor in the room: they amplified the tone from the naïve, though condescending, optimism of behavioral public health to anticipated antagonism. They spoke about the risk to—and of— the rural and illiterate people of Kono, the fact that their subjects *would* spread this disease if, in fact, it came and they were improperly sensitized. In some ways, the script seemed already-written; the public health messages insisted on rural Kono people not knowing how to behave and adhere to self-protective measures, and the Chiefs' prognostications insisted upon an antagonism between the *commandement* that they embodied and their subjects. The room, in other words, had turned a microcosm of regimes of authority; the public health threat was invoked to buttress local forms of political power.

The following week, however, the scare from those first cases in Kono fizzled; we did not hear anything about them again. But in the coming months, public health messages, posters and news reports proliferated in the region explaining about this frightening new disease that killed many of its victims. It seemed like every NGO got on board and added to the sensitization: *Ebola caused bleeding and was spread through touching other infected people. Do not eat bush meat, do not touch those who have traveled to Guinea and are ill!* And indeed, in late May, the first cases of Ebola were diagnosed in Sierra Leone in a border village south of Kono. The story we heard was that a family had attended the funeral of a local healer in Guinea who had been

treating Ebola patients in her home. As is customary, they had likely washed her corpse before burial and contracted the disease.

Those first cases were isolated, as per the national plan, at the public clinic in Koindu Village where they had presented. They were to be transferred to the hospital in Kenema that had been designated the site for Ebola patients. But soon, a family barged into the Koindu clinic, demanding to take the people waiting for transfer to Kenema back home. More cases emerged from Kailahun. And in Koidu, soon afterwards, I heard patients waiting at a food shack near a clinic talking about how the government was trying to eliminate the Kissi Tribe—the inhabitants of the region where the outbreak began—in order to shift the census for the upcoming elections. Outside of the clinic, a woman yelled: "Ebola is a lie! They're sending people to Kenema to die!" This was the first time I heard the phrase, "Ebola is a lie," but it would be repeated many times on WhatsApp, in person, and in dozens of articles characterizing the rumors and social complexities of peoples' denial in the year to come. What really did it mean? That the virus did not exist? That the Ebola situation was a lie? That global health was a lie?

A few weeks later, I received a call from a colleague in town who said I shouldn't meet him for lunch as we had planned. People in town, he said, were saying that two children had died after receiving routine vaccines during a national in-school vaccination campaign. I was at the clinic, and in the sitting area of the Women's Health Center, a woman yelled into her cellphone in front of the women waiting for antenatal care appointments: "Go pick up Kumba! They're injecting Ebola and killing patients!" She had a ferocity and volume as if she were speaking mostly for the other women around her. In Kailahun, Ebola continued to spread as villagers reportedly stoned health workers. Ambulance drivers described youth building ditches to prevent them from entering communities where the nurses had reported Ebola patients, and in another

village a medical store was burned to the ground. The disease moved rapidly through rural communities in Kailahun and Kenema, and soon thereafter, to Freetown and beyond.

In those early months, those uncomfortable prognostications voiced by the Chiefs and NGO bureaucrats in that first meeting about how Ebola would spread due to resistant and nonadherent villagers seemed to be bearing out. A Manichean struggle—a spectacle— between the increasingly-militarized public health responders and resistant rural West African villagers seemed almost pre-ordained, like the script was written, each side quickly taking on their roles, in tandem with that initial zoonotic jump. Foreign experts arriving in the country to help manage the containment efforts fixated on rumors as a central obstacle to achieving community "buy-in." As Guillaume Lachenal (2017) has written of a 1950s sleeping sickness campaign in Cameroon in which similar dynamics were at play: "Eradicating the disease was not a matter of eradicating pockets of resistance, in the literal sense of the term: epidemiological thought became openly political" (108).

A new assemblage of experts, funding and interventions came from abroad to develop what became called a field of "social mobilization." In some cases, it seemed, families were waiting too long to call their local clinic to report someone with a fever. After all, the vast majority of people at that time with a fever did not have Ebola, and those who were taken away by the Ebola ambulances were often never heard from again. In other cases, local people threatened more overt forms of violence against teams from the Ministry of Health and NGOs sent to trace the contacts of people who had been diagnosed with Ebola. But these two issues—on the one hand, a kind of harbored skepticism towards the exceptionality of any one patient's disease, and on the other, a spectacle of defiance—were collapsed together and collectively called "resistance to care." NGOs hired anthropologists to convince people to call for

healthworkers when a relative or neighbor was ill (Desclaux et al). In Freetown, behavioral health experts groveled for answers as to why the people from hard-hit communities were often not calling for ambulances or worse, attacking healthworkers. I met one young American woman who worked for a UN agency managing subcontracts to NGOs, who spoke with intensity and earnestness about her interest in what was by then called the "social mobilization pillar" of the Ebola response. Recently graduated from a global health sciences Masters program and excited about the possibility of data-driven behavioral health campaigns, she described wrestling with how to test and tweak the messaging that would be "pushed out" through their NGO networks: motorbike parades, radio jingles, community healthworkers and posters to get people to comply more with the mandates not to care for the sick or bury the dead. In some ways, it seemed unprecedented that a UN manager was thinking about the social contexts in which the epidemic was unfolding and in which health information would be experienced. But her mode of narrating her enthusiasm surrounding these intellectual quandaries about "pushing out" "messages" and tracking minute changes in case counts— as if Sierra Leoneans were automatons whose behavior would be incrementally (though measurably) different if the line blasted through a staticky speaker on the back of a motorbike in the hinterlands was altered from "wash hands to prevent Ebola" to "to protect your family, wash your hands"— seemed to belie common sense about how human cognition worked.

I knew there was terrible chaos unfolding in Kailahun at the time. NGO-operated tent-cities had been constructed quickly, the ex-patriates were largely sequestered inside and shuttled to and from their compounds. Land Cruisers with sirens bombed around the narrow forest roads, and Sierra Leonean healthworkers dressed in space-suits materialized in small villages and roughly handled patients before they were thrown in ambulances and often disappeared. The

logisticians from *Doctors Without Borders* were the ones calling the shots; clinicians—even those who had volunteered from abroad— were not permitted to provide any substantial supportive care for patients, and the more "people-centered" (Biehl and Petryna 2013) aspects of managing a situation like this—accompanying patients, explaining the situation transparently to relatives, acknowledging the gravity of the situation—were effaced under the pretext of urgency. Not to mention the fact that uninfected people were contracting the disease from ambulances and unsanitary holding centers. Perhaps the rumors and resistances were a way of speaking to this experience of dissolution, anxiety and the loss of control to opaque institutions, notions of epidemic threat and material risks of Ebola exposure and transmission.

But rumors here have long been vehicles for transmitting both concrete information and structures of affects surrounding contingencies and danger (White 2000; Shaw 2002a). And rumors—and the confounding and "resistant" behaviors they may beget—have also always a fixation of public health experts in the region, and "proof of African superstition, and of the disorder that superstition so often caused." The antidote to this reductive culturalism offered by anthropologists has often been to demystify rumors as if they convey coherent historical truths: for instance, as born of rational aversions to the healthcare system after many years of bad experiences ("they're injecting people with Ebola to kill them in the treatment unit!") (Ferme 2014); a reflection of the corruption and cronyism of contemporary Sierra Leonean politics ("they're killing the Kissi people to shift the census!") (Batty 2014); or a more abstract comment on the histories of colonial predation in the region (Richardson, McGinnis, and Frankfurter 2019).

But Achille Mbembe writes that in the West African postcolony, rumors are also a kind of disposition towards politics that appear absurd and arbitrary, one that operates more at a

register of signifiers than signified. In the postcolony, "you just have to make the best of things," Mbembe writes:

> If, to repress the population, the autocrat uses water cannon, tear gas and guns, then he is resisted as best as possible with the help of the 'poor person's bomb,' rumor. An ex-banker who had taken refuge in Canada suggested that the wife of the head of state was responsible for the collapse of one of the country's most prestigious banking establishments. It is [also] said that the [chief executive of the national oil company] is dead. Did you hear?' For it is enough to have heard the tale with one's own ears for it to be true and for one to pass it on. 'yes, yes, I heard that too. So it must be true!

Mbembe frames the rumor as a practice of irony, humor, born of groups of men free-flowing and riffing off of each other, connecting dots in new ways in the face of a regime of politics that seems overwhelmingly nonsensical, indifferent, arbitrary.

> When evening comes, the men may meet up in the corner bar. In this masculine world—albeit not always—men don't come simply to quench their thirst. They also come to laugh: "When something gets too much for me, I just laugh." They talk endlessly, too. They pour out their feelings, and somethings they fight. They borrow money. They give way, the better to take advantage. They make themselves understood from what is not openly said or shown. They endeavor as it were, to make visible what, a priori, does not possess visibility (Mbembe 2001:158).

Mbembe suggests that rumor is medium through which "ordinary people bridle, trick, and actually toy with power instead of confronting it directly" in the postcolony. Rumors here need not speak to *belief,* nor necessarily reflect coherent convictions. Rather, they express peoples' recognition of the limits of their own agency, and are a kind of *bricolage* of symbols and aesthetics of postcolonial violence and uncertainty. Seen in this way, rumors that "Ebola is a lie" or that it was a scheme to get rid of the Kissi tribe may be more carnivalesque, comedic, a comment on the depravity of politics and farcicality of rural Sierra Leonean life—that the Big

Men would engineer a virus to wipe out a "tribe"— than superstitious. These rumors drew attention to the absurdities of the Ebola response more than the technocratic: the policemen manning checkpoints at the time wearing haphazard and singular of personal protective equipment (a glove here, a boot there); the tent cities put up in a remote corner of Kailahun; the fact that men and women who only had a fever were manhandled into ambulances and simply disappeared. Rumor is the medium through which local people are drawn into, and contribute to, the "aesthetics and stylistics" of opaque and often-violent postcolonial politics (see also Monga 2016).

But in Sierra Leone that year, these rumors did not remain just comedic articulations of the arbitrariness of life; they materialized into violence that matched the excesses and spectacle of the growing response.[1] On July 29, as I drove to Freetown in order to leave the country for some months, I remember hearing over the radio, interspersing the AfroBeat songs, reports of one catastrophe after another happening in real time. Dr. Sheik Humarr Khan, the figurehead of the national response and a beloved doctor who had run the Kenema Lassa Fever Unit and the Ebola Treatment Center had contracted the disease several days earlier. There had been so much concern about the rumors that might circulate if local people found out that an experimental Ebola treatment were provided to Dr. Khan and if he were to later die, that foreign MSF clinicians *withheld* the drug from Dr. Khan (Pollack 2014).[52] (It was later delivered to two American missionaries suffering from Ebola in Liberia who survived). On that drive, the MC announced that the Kenema hospital staff had gone on strike, incensed over delayed salaries and lack of hazard pay, and Dr. Khan died (*"may he rest in perfect peace"*). And Ebola patients, the

[52] MSF representatives also reportedly claimed that providing Dr. Khan the drug and not others in the treatment unit would be inexcusably inequitable (Reveal 2021).

radio announcer said, were spilling out of the hospital there and were being taken back by their families. Within weeks case-counts had exploded across all the urban areas of the country.

The Riot

In late October, a local strongman named Akin instigated a deadly riot against Ebola responders in Kono. Media had reported (first in the tabloid local papers, and then reiterated in international media) that Akin's sister had first fallen ill and was illicitly buried. A week later, Akin's mother also began to display Ebola symptoms, and ambulance attendants were called to remove and transport her to a treatment center. Akin rallied a group of young men to bar their entrance to her house. Police and soldiers arrived, and this led to a brawl. Different newspapers reported differently how the two young men had died, and many of the stories read like rumors themselves. A "machete-wielding" mob had killed the boys, one reported; another said that the police, ready to show their might against the Kono gangster, fired into the crowd. The city was put under a lockdown and curfew and healthworkers were evacuated from the hospital (with Ebola patients inside) due to the violence (Johnson 2014; Perez 2014).

I wondered, at the time, if this was the kind of inevitable extension of the rumors and exclamations that began to circulate outside the clinic in April 2014: *"Go pick up Kumba! They're injecting Ebola and killing patients!"* But as I spoke to David and others about Akin's role in Kono's political landscape, I learned that this eruption of violence was not borne of the history of the Ebola epidemic alone. Akin is referred to by many as a criminal, involved in smuggling networks alongside Lebanese traders, and many of the young men who hang out in the *djamba* ghettos reference him as a gang leader. In written histories of the civil war, he is

named as a commander of child soldiers who perpetrated atrocities on civilians in Kono. But while Akin is considered a dangerous and destabilizing presence in Koidu today, his acts of brazen disregard for political and social norms today often seem more farcical than dangerous.

For instance: one of Akin's most recent stunts occurred during a football gala organized in Koidu by a Big Man from the ruling political party. Akin, who is allied with the opposition party (and its insurgent wing based in Kono), was supporting a team that was winning but felt maligned by the referee who gave a free kick to their opponents, equalizing the score. "I don't really know what happened because I was standing on the other side, but another *fracas* broke out," David told me, "and some people tried to manhandle the referee." Akin stormed on the field and grabbed all the trophies from the table and carried them to the ghetto where his boys smoke *djamba* and would protect him. "Because of that, the other guy, the politician, who organized this team also pulled his own strings and they sent some army guys and really came and manhandled him [Akin] and took him to the army barracks. And some of us were dismayed!"

The next morning, the soldiers simply let Akin go and he was back on the streets again. The dramatics were complete. But David and his friends spoke about Akin with complete reverence: "I can't believe…not many people would have done that one. That's Akin for you!" I must have had a confused look on my face: the most violent, political radical youth leader's stunning act of political resistance was publicly stealing a soccer trophy? "Well now, that's it!" David said. "If it is the cat kingdom, and he's a rat, he would be the one to volunteer to fell the cat!" To participate in the spectacle, to understand the way it structures political relations and imaginaries in Kono, is to cultivate a sort of indifference to the threat it might—or might not—

entail; to always know that, at the turn of a dime, the theatrics can switch into a kind of overwhelming "economy of death" (Mbembe 1992) .

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Some five years after the riot, I met Akin on the grounds of former Vice President Sam Sumana's mansion in Kono. Sumana had just re-entered the country after being sacked and exiled due to a salacious squabble with the President, and was trying to start an insurgent political party to contest the All People's Congress's hegemony on national politics and its continued neglect of the region. Sloping hills led down from an ornate mansion where clusters of men talked in chairs under shaded trees. Akin was serving as Sumana's security.

Akin did not need prompting to tell me about the Ebola riot, his most recent defining act. "They came to me and said, 'Your mother has Ebola,' and my mother didn't have Ebola. My mother had *rheumatism* and *old age,*" he told me, drawing out the names of her conditions. She was supposed to be receiving daily treatment. "The man who took care of my mom…he was the vice chairman for the APC [party] and he was on the Ebola team. So he stopped giving my mother [medicines] at that time [because] I had a grudge with them…so he just formulated this thing so it would pressure my mother."

Amidst the political tensions at the time and the central role Akin played in supporting the opposition to the APC party, I could completely understand his discomfort with an avoid APC man taking care of his mother. His accusation that the man "formulated this thing" seemed tacked on at the end, a vindication of his description of how political anxieties had become enfolded into his mother's medical care. The mother's condition worsened, and, Akin said, the

nurse-cum-APC-operative reported her condition to the Ebola command center. Ambulances, contact tracers and police showed up to take the woman away.

> The police came and talked to me, and I said, 'No.' I didn't stop them, but I said: 'Anywhere my mother goes, inside the car, they should not spray there with chlorine,' because chlorine suffocates people, they get weak. And when they are weak, problems will come, Ebola might come catch you finally. And anywhere my mother goes I should be there too, because a person should take care of her. And where they were taking people [at the time] they left them carelessly until people died. There was no care then. ...They said I couldn't come, so I said 'Ok, she won't go!'"

The chlorine sprayers, space suited men with tanks of solution on their back who followed patients everywhere and sprayed the ground in their wake, were a central feature of the aesthetics of the epidemic situation at the time. People who had tested positive and who often initially looked visibly normal walking into and out of ambulances and treatment units had their shadows constantly sprayed with this clear but caustic chemical. The fumes from the chlorine used in the treatment centers to sanitize patient areas and to spray healthworkers as they carefully removed protective equipment were overpowering in the areas around the treatment units. I heard people in Kono say that perhaps all this chlorine was making things worse for patients; that even if those inside the treatment units were sick with a deadly virus, this noxious spraying everywhere would certainly worsen patients' health. But it almost seemed like Akin was referencing the chlorine to me as an after-the-fact justification for an inevitable conflict.

Akin grabbed his mother from the healthworkers and left, he said, as the boys who follow him attacked the police. The police teargassed the house where he had hid his mother and took the woman away. She died soon afterwards; he did not say, or perhaps did not know, where. Akin fled to the bush and hid in a camp for some weeks near the border with Guinea until he was spotted by a motorbike rider and arrested. I saw WhatsApp videos of the dramatic arrest. Police

and camouflaged soldiers leaned in one by one to flog Akin, whose shirt had been torn off and who looked wounded.

Akin said he spent nearly eight months incarcerated—first in Kono, and then in Freetown's notorious Pademba Road prison. I asked Akin whether, in retrospect, he thought Ebola was even a real disease that spread through Sierra Leone in 2014, or if he believed that "Ebola is a lie".

> Ebola…is there. It exists. But I did not see the signs and symptoms on anybody in Sierra Leone… I know what the signs and symptoms of Ebola are. From where Ebola first emerged, I know how they say Ebola should appear on a person….all over bloodiness in the body. Blood comes all over you, it comes out of your nose--not like a sneeze. It comes out of your eye when there is wound. It comes out of your ears--any place where you have a hole on your body, your mouth, your anus…you're private…everywhere blood comes out.

Akin suggested that the sensational way that the disease was first introduced in the Sierra Leonean media contributed to the panic and—when most people who contracted the disease did not look like the stereotyped Ebola patients or have any connection to consuming bushmeat—a kind of disbelief. This is a similar point to that public health researchers have made in their post-mortem analyses of "what went wrong" in Sierra Leone (Walsh and Johnson 2018: 46-47). Information that Sierra Leoneans gleaned from WhatsApp and social media, itself looping and drawing on the way Ebola had been characterized in American media like Richard Preston's sensationalized book *The Hot Zone,* augmented the catastrophizing discourse that circulated about the disease, its high fatality rates and zombie-like presentation.

But Akin did not dwell on this explanation for his reticence to accept his mother's diagnosis; instead, he shifted to the question of whether one could even distinguish Ebola from the general state of poor health and neglect in Sierra Leone.

> Listen, we have certain sicknesses in Sierra Leone that are normal sicknesses: we have bleeding ulcers, we have dry cough—this TB— we have dysentery, we have pile, we have different sickness, we have old age sickness so this all they call…you get malaria, you get sinus fever...all of this they gathered and they said: 'Ebola signs and symptoms.' Even malaria, ordinary swelling, a boil, they said are the signs and symptoms [of Ebola].

This was not the first time, Akin made clear, that death was accompanied by lots of blood spread out and through many bodies. But when I asked him who "they" were, *who* would "gather all these symptoms" as Ebola, he shifted to the conspiratorial again: "They have their aims and objectives, to fill their own blank spaces, and the White People— *they have their own arrangements*." He said he had heard, for instance, that during the epidemic, in the airport, police had found a bunch of body parts being sent to South Africa to be used in scientific experiments, which had been taken from people in the Ebola treatment centers. This was the kind of conspiracy that had so captivated journalists and public health practitioners in its exotic superstition; ironically, in this telling, the State was not implicated as participating in the conspiracy, but rather in attempting to surveil and prosecute it. I too saw an opportunity to read critiques in Akin's conspiracy, those same critiques anthropologists have read into occult anxieties that have proliferated throughout the millennial continent: of the violence of extractive capitalism by harvesting body parts, of the lived histories of medical experimentation on African subjects, and of the role of the Freetown airport as a nexus for global, shady flows of commodities and money, particularly to South Africa, where many of Kono's diamond magnates—including those who run the Koidu Holding's mine—originate (Comaroff and Comaroff 1999; Moore and Sanders 2002; Lowes and Montero 2018; Richardson et al 2019).

But then Akin settled back into his chair: "I'm not saying Ebola doesn't exist, but I didn't see it here…Even in court I spoke that."

*

And thus violence erupted, born at some level out of a set of disarmingly earnest and tender concerns: of his mother's suffering from *old age* and of his desire to accompany her wherever she went. On the one hand, Akin narrated a set of banal concerns of familial piety and anxieties surrounding how is mother would be treated given the tenor of urgency during the epidemic. Akin conveyed a kind of quiet, but not emphatic, skepticism about what was going on—"I don't believe that Ebola *came*, but Ebola *exists*." His desire to be with and care for his mother, for she was sickly already and more so how would they know that she had Ebola—his doubt was, perhaps, born of his not *wanting* to believe she was terminally ill. Indeed, while it is now taken for granted within histories of the Ebola epidemic that Akin's mother had contracted and died from Ebola, it is impossible to know whether she was tested, nor what the results revealed. There are no records, no "truth" to be uncovered—then, and now, it is the regime's word against Akin's.

On the other hand, the healthworkers and the local authorities alike had *a priori* precluded the possibility of a peaceable encounter, guns blazing, because this was Akin, the insurgent thug, the object of the military's brutality. He knew that despite the messages at the time— "If you are sick call 117 and an ambulance will pick you up" and "these rural people will bring it on themselves for refusing to believe!"— the Ebola epidemic would inevitably be harnessed by regimes of political authority that viewed Akin as threat. The violence seemed a foregone conclusion, bolstered, at some level, by the aesthetics and affect flowing out of the Western humanitarians high on their mission, in their military-style safari vests, the

epidemiologists warning of superspreading disease-vectors, a British incursion of helicopters and army-vehicles saturating the country, and a landscape of postcolonial politics in which wonton brutality towards subversive characters is a key way in which the ruling party maintains its allure.[53] This was a shared repertoire of war-time action again; this spectacle, in turn, demanded violence of Akin.

Akin's oscillations between these two registers of memory were uncomfortable to hear, for he left unresolved where his own agency lay. Could he have refused to engage? Could he have stunned the mob of police by acquiescing to his mother being taken away? In the end, perhaps his defiance amounted to a kind of knowledge born of experience: despite the messages at the time— "If you are sick call 117 and an ambulance will pick you up"— this was a situation that would inevitably be harnessed by regimes of *commandment* to conjure collective affects of force, brutality and spectacle, and would also inevitably be dealt with among families, households and friends, by a son taking care of his mother because she would not receive attention at a facility, by a family relation hanging a drip for a woman's old age.

The Mop-Up

Soon after Adamu's riot in Koidu, the Sierra Leone President transferred authority over the Ebola response from the Ministry of Health and Sanitation to the Ministry of Defense. Some

[53] This last point, of course, is reiterated by Adamu in his conspiratorial rendering of the APC party trying to eliminate him as a threat to their patronage networks and hegemonic grip on Kono.

donors lauded this move as signifying that the government was finally "taking seriously" the situation given that the "command-and-control" culture of the military might be better suited to manage the logistics of the response and the violence unfolding in rural areas. "'I am now using the 'carrot and stick approach,'" Major Paolo Conteh, the Sierra Leone military official who was appointed to be the head of the National Ebola Response Center, was quoted as saying. "I have been giving out the carrot since I took over but our people still do the wrong things. When I start using the stick, I will see all kinds of headlines in papers and radio programs but will not be deterred by them (Awoko Editorial Staff 2014).

The new structure also decentralized response efforts, formally outsourcing what was already an improvisatory and largely unsupervised set of response activities in the peripheries. In each district, a District Ebola Response Center (DERC) was made responsible for managing the response on the more local level, overseen broadly by a National Ebola Response Centre (headed by the Minister of Defense). A District Coordinator led the DERC, and he was to be appointed under the direction of the President of Sierra Leone. In some ways, it was all too predictable who the President had appointed to run Kono's Ebola Response Center given their intimacy developed through years of managing the Koidu Holdings mine's expansion. The President had handed Paramount Chief Sumana—the former Georgia truck driver turned Paramount Chief, who had served as the go-between between the Koidu Holdings mine and the surrounding communities it was displacing—the reins over the Kono District Ebola response.

In December, I witnessed a militarized operation in an Ebola hot-spot community of the sort threatened by Major Conteh. A few days beforehand, I had attended the Kono District Ebola Response Center (DERC) meeting on the outskirts of the Koidu Holdings diamond mine. James, a British ex-military advisor seconded to the DERC, sat at the elevated table at the front of the

room next to the Paramount Chief. A young man from the surveillance pillar had stood up to give his report: *"This Ndambie* is really, really getting out of control!" The large number of Ebola cases from the town of Ndambie, he had now learned, were connected to a burial some two weeks back. A taxi driver in the town had died. Apparently, the driver had gone to the hospital and was told that he had a stroke, but because the Red Cross had shut down the hospital to sanitize and reorganize it after so many Ebola patients had died, the man was sent home without much examination. The man had died, and the family called the Ebola Alert Hotline to request a burial team to remove the body. "But the swabbing team," the spokesman said, raising his pitch and shrugging, "had taken over 48 hours to show up." In the meantime, the corpse had laid in the house. At a certain point, the dead man's family and friends could not take it anymore and carried the body to the Mosque and washed it for burial. *"So you see?"*

The Chief interjected: "Well, it's really about time that we have another one of these mop-up operations. Major Crosby? 5AM on Wednesday morning?" I had heard that the military had conducted one of these "mop-ups" in an another village where the virus had been spreading. Soldiers swooped in unannounced before daybreak to search house-to-house for patients in hiding. The photographs and stories I had seen looked like a full jungle warfare raid, with soldiers half-covered with plastic medical gowns slinking into thatched-roofed houses and health workers pointing infrared thermometers at peoples' heads like pistols. An American colleague who had been there told me that he had been somewhat unsettled that the villagers had acted so stoically amidst the theatrics, as if the soldiers' behavior was expected and not something that warranted much anxiety.

After the evening meeting wrapped up, we moved to a different conference room to discuss the plans for the Mop-Up. I had only just arrived in Kono and was reluctant to insert

myself at all into the meeting. But I had closely followed the situation for the prior few months and in daily calls with colleagues in Kono, and this tactic seemed incommensurate with the chaos revealed during the pillar reports. After all, the corpse-swabbing team had never even shown up, although I did not know at the time what to make of the Chief's own initiative in designating such a response, nor of my colleague's assertion that in the prior village people had seemed so unphased by the soldiers.

I spoke with several others who had been attending the meetings for weeks, and eventually a colleague raised his hand and suggested that perhaps the community healthworkers could do a house-to-house screening in Ndambie instead of leaving that up to military. The Chief, said he didn't like the idea, that "these rural people are better met with force." But James, the British advisor sent to assist in the management of the DERC, expressed some curiosity. He couched the idea in appealing terms of military incursion: as a former solider himself, James knew it was probably worth trying a "soft approach" towards the village, but keeping open the possibility of a "harder" one should "the community not comply."

The Chief readily acquiesced; he clearly had great respect for James when he invoked his powerful military background: "Let us see how this experiment actually works."

A few days later, we assembled outside the District Health Management Team office before dawn. The Chief had insisted that even if community healthworkers rather than soldiers were to lead the operation, we had to arrive in Ndambie before sunrise, that the villagers must be caught by surprise, before they headed off to their farms or mines. Soon, a caravan of pickup trucks, SUVs, NGO vehicles, Land Cruiser ambulances and military trucks filled with camouflaged soldiers snaked its way out of town. I was silent, squeezed in the back of an SUV; it felt like we were approaching a night-time raid. I could tell the community healthworkers, who

had rather tedious day-to-day jobs, were nervous and excited at being in such proximity to the soldiers and their weapons.

The caravan pulled into the site that James had called the "staging area," selected from a Google maps print-out of the town. This is where the soldiers were to station and wait. We unloaded. Most of the vehicles turned to pick up more people, and I hung back as the healthworkers fanned out in teams of two or three to go house by house and ask if anyone was ill. They had a script that I heard inflected with an awkwardly infantilizing tone—*"are you sureeeee there isn't any one person in your household who might have a fever?"* The Chief and other DERC managers had insisted that those going house-to-house ask every member of the household to come outside to prove that no one in the house was sick, and that they make proper investigation through studying how the villagers answered their questions. *Where were these sick people hiding?*

This operation was not driven by a logic of biopolitics. This was not about safeguarding, enhancing, facilitating the health of the population—nor even of containing an epidemic. This was about excising threat. The logics governing this house-to-house incursion seemed, in a sense, the flipside to what anthropologist Samuel Anderson has called "the logic of *politics by prospection,*" in postcolonial Sierra Leone. This is a politics that makes claims of ushering in "radical social transformation"— from "Pentecostal crusades to protest movements and populist rallies." – via affectively-laden spectacle which functions in part by diverting attention from the ongoing material sources of precarity: Anderson notes that prospectation "evokes a quest for hidden resources across promising strata." But these forms of political performance that *promise* transformation of collective life-chances may also focus on the *excision* of threat, from the political campaigns staged across the continent to identify and eliminate witches, to the mass

sacking of political leaders who threaten sovereign authority, to, in this case, a scanning for vectors of disease when there was still little material infrastructure for Ebola containment let alone care. Like the witch guns that had been shown to me years earlier at Traditional Healer's Union, these Ebola patients could be disarmed and removed, even though the delayed swabbing teams and horrific conditions in the government hospital remained unaddressed.

I watched the healthworkers go house to house; I could not see the inhabitants come out and affirm their health from where I was standing with the Chief and the few other expatriates: one brawny epidemiologist from New Zealand wearing the blue, pocketed vest of the World Health Organization, and two American CDC epidemiologists seconded to the Kono DERC. I was not sure why they were there; ostensibly to "handle the data," or maybe just to embody some institutional presence or expertise. At a certain point, I went back to sit and read in the car, uncomfortable with the voyeurism of it all. People passed me updates: *"We found one!" "Over there, they found one sick person!"* Ambulances clambered up the rutted hill into the town flashing their lights, and then back towards Koidu where the patients would be deposited in the holding center.

Eventually, I took a walk through the quiet village, and one of the healthworkers on his rounds pointed out the mud-brick compound where that first taxi driver had lived and died. It was encircled in red-and-white ribbon signifying that the inhabitants were under quarantine. Beyond the ribbon, looking unphased, a woman and some children sat in front of a fire, beginning to prepare the rice for the rest of the day. They were the only inhabitants of the village that I saw that day; the rest remained in their homes, asked only to come out when being screened to ensure nobody was secretly sick.

As the day heated up, the military kept edging closer to the village. Someone parked an ambulance at the base of the hill into town and just left the siren on. This only seemed to prompt the soldiers to enter further into the town, and soon they took over the exercise, bombing around in their vehicles and screaming at people to come outside.

I walked down to the junction, where I saw a crowd of police, soldiers and bystanders clustered around the veranda of a cement house. A large man in a t-shirt was screaming at a group of children who looked at their feet and sucked on their fingers in a perfect line. Someone leaned towards me and whispered: "Their father has Ebola and ran away to the bush! They are being asked where he is—they must know!" The screaming man was swaying on his feet, slurring his speech. I asked who he was; he said it was the Paramount Chief of this area. I turned to one of the community healthworker managers nearby and asked what he made of this encounter. He shrugged, consumed by the scene unfolding in front of him of the children cowering from the Chief. As Mbembe writes, these acts of quotidian violence and surges of authoritarian power are not always resisted or even problemetized. "The practices of ordinary citizens cannot always be read in terms of 'opposition to the state', 'deconstructing power' and 'disengagement.'" The NGOs' community healthworkers, rather than representing an approach distinct from that of the spectacular *commandment,* were inseparable from it. And the military seemed to be largely under the command of the Paramount Chief, rather than the other way around.

As I tried to walk back to the vehicle, the Paramount Chief pointed at me. He demanded that I come eat outside his compound. I tried to slink away but his associates insisted. In a half circle beneath the massive compound he was building across the street, a house made of concrete dribbles that looked like a sandcastle, we ate goat stew while watching the pandemonium

continue. The Chief, plastered, continued to rail about the stupidity of the uneducated children hiding their father, that something must be done. He did not engage me again, and I left as soon as I could.

I never learned how many Ebola patients had been found in the operation. The number "seven" was widely circulated, but communication became fuzzy and we did not hear the results of the blood tests of those taken away by the military and ambulances. This "outcome" did not seem to be a great concern. I had suspected that at the DERC meeting the Chief would use the chaotic conclusion to the day as a reason to return to having the military run these house-to-house mop-ups on their own, without community healthworkers involved at all, and I called James to offer a pre-emptive explanation. But the next day at the DERC the Chief was overjoyed at the operation. "That was a great, tremendous success!" he said, buoyant and gregarious.

The following week, the outbreak at Ndambie just seemed to peter out. The focus of the DERC meetings shifted soon to another village that was becoming the epicenter of the District's outbreak. Like a wave—or an invasion at Aberdeen— the vehicles, the soldiers, expatriates, the ambulances, the community healthworkers, the causal scripts of backwards villagers and fleeing patients had immersed Ndambie village, and then, just seemed to withdraw.

Underneath the Spectacle

When I returned to Ndambie some three years later to learn more about the stories of the survivors and their families there, not a single person I spoke with mentioned the Mop-Up

operation. It was as if that whole incursion hadn't even happened, or was merely a distant, and inconsequential, memory.

But signs of the post-crisis humanitarian political economy were everywhere. A large, rusted billboard had appeared in the junction into Ndambie with a photograph of the former President awkwardly smiling, his lips meeting in the middle, with a young girl on his lap. Under the photograph was the imperative: *Do Not Stigmatize Ebola Survivors!* Little project signs dotted the town, labeling agriculture projects, educations schemes and psychosocial support programs funded by a range of international NGOs.

In the intervening times, Alliance for Health Justice had hired many of the Ebola survivors as healthworkers and auxiliary staff, and they had become the public face of the organization's work, both to donors and within the country. I had seen this economy of survivorship before, of targeted resources for an "exceptional" patient population even though the whole town seemed so impoverished and in poor health: in the economies of trauma narratives exchanged for food support surrounding the amputees; the same had occurred some years later with the HIV patients (Benton 2015; Berghs 2016), and in the ways pregnant women and children had, after the Free Healthcare Initiative, become the primary patient-subject populations in the country. The resources these that these evolving phases of global health brought served as lifelines for these "exceptional" patients, but I had seen that they could have troubling unintended consequences, as in the case of the amputees who had been resettled into "Amputee Camps" and, wrested from their networks of kin and social support, now lived in destitution, recalling the bags of rice that used to come, emphasizing in every interaction with me their disabilities and isolation. Indeed, one Ebola survivor told me that the aid had all dried up after just a couple years: "People forget quickly." People from what were called the "death

houses," who had not contracted the disease themselves but lost many family members and life-sustaining income, had received nothing.

The organization's staff connected me with a survivor named Yusuph in Ndambie to show me around the town. I told him that I had watched things unfold in Ndambie from the vantage point of the response and was curious about what had unfolded within homes and families at the time. When I said that I had been there at the mop-up operation, he looked puzzled as if he too was not sure what I was talking about. Then, he remembered: "*Ahhhhhh yes,* someone called us in the treatment center and said that the army came so early in the morning!" But that was all he knew; those within the village did not speak of the incursion as particularly traumatizing. That sense of there being a space between spectacle and audience—like that conveyed through David's story of the invasion on Aberdeen beach—permeated our conversation as well.

Yusuph was a gregarious elder in the town and had worked as a tailor before the outbreak began. He had a playful energy during our walks thorugh the town, prone to letting out a raspy laugh and an elbow in the gut when explaining a humorous period in his life or that of the village. Yusuph had been elected the Chairman of the Ebola survivors in Ndambie. Each Ebola-affected village had appointed a "Chairman" and an elaborate bureaucratic leadership structure for the local survivors' group who would liaise with the Sierra Leone Ebola Survivors' Association.[1] Yusuph's role as Chairman today, however, seemed primarily to act as gatekeeper for the NGOs and researchers who swooped in and out, promising inclusion in research projects, services and transient resource distributions.

The Ndambie outbreak all had all begun, Yusuph told me, with a beloved taxi driver named Pa Bangura. This was the man I had heard about years before in the DERC meeting, the

corpse that had apparently lain for days outside the family house. Yusuph told me that Bangura was one of the few in the main town to own a hirable car. “Pa Bangura was someone you could call on at any time, aaaaaany time of night, to drive you to the hospital. You’d call and he’d say: ‘Ok, just a minute, let me get my things.’” At some point in late December, Bangura picked up a sick woman a bit out of town, and drove her to the hospital. Bangura’s friends disagreed on who this woman was: it was unclear if Bangura merely met her along the road or took her from another village that was known to have Ebola patients, if she was fleeing a nearby village where the military had run a mop-up campaign searching for Ebola patients or if the woman was a friend who had called Bangura directly for a ride. In any case, she got in his car, and soon after vomited all over the seat.

After dropping the woman off at the hospital, Pa Bangura returned to Ndambie. He called a few of the younger men who stayed near his compound to wash out the vomit from the car. Yusuph intimated that it was possible that some of the group were concerned that the passenger could have had Ebola, but Pa Bangura was known for carrying sick patients to the hospital, there were a lot of sick people in Kono, and furthermore: what was there to do? Pa Bangura needed to continue his driving business; life went on even amidst the Ebola scare.

A week or so later, Pa Bangura began to feel ill. He called a close friend named Paul, a sort of surrogate son, from a village a mile or so away to let him know. Paul, who later contracted the disease but survived, recalled that all night Pa Bangura had had diarrhea, so he recommended that Pa Bangura take some antibiotics from the pharmacist.

Several days later, Pa Bangura’s friends insisted that he to go to the hospital, so he took a motorbike taxi. As a relatively well-off man, Bangura had had a long-term relationship with one of the two doctors who worked at the hospital, Dr. Mahmood. Dr. Mahmood had treated Bangura

before for hypertension, and when he examined Pa Bangura at the hospital noted that Bangura seemed weaker on one side of his body, and thought he may have had a hypertensive stroke.[1] The Red Cross had shut down the hospital as part of its Ebola containment strategy at that time, so Bangura could not be admitted to the hospital for a further workup even though Dr. Mahmood would probably have done so if he still had authority over the facility. So the doctor called a nurse from a clinic near Ndambie to provide Bangura with supportive treatment at home. That nurse refused to help, given his fear of contracting Ebola. By this time, the anxieties surrounding both the virus and the response had so clearly ruptured social connections and norms of caregiving and reciprocity, so Dr. Mahmood called another nurse named Christiana. Christiana was also reluctant to help, but Dr. Mahmood insisted that the man had had a stroke and just needed supportive care. Christiana thought about it and agreed to provide Bangura with an IV drip and some other medications at home.

Pa Bangura's condition worsened, and later that week, he died at home. Somebody, a friend or family member, called the Ebola hotline as had been instructed to report the death and request a team to remove and bury the corpse safely. But given that Dr. Mahmood had cleared Pa Bangura of Ebola, his family and friends had held a Muslim funeral during which the corpse was washed per tradition. Then the family lay the corpse outside again, where it was swabbed and buried by the men in space suits the following day.

A few days later, the family received the result of the swab: positive for Ebola. Christiana the nurse was the first to hear, and she called a friend: "Did you hear the results, did you hear the results of the test?" Yusuph, who had attended the burial and had helped care for Pa Bangura when he was sick said: "When we heard the news, we thought: 'We are all finished!'"

This was the beginning of the Ndambie outbreak. I was struck by how this story implicated so many actors in troubling ways. The Red Cross's domineering approach to the hospital, deprioritizing patient care under the pretext of urgency and rigid safety protocols that effaced questions about the ethics of turning away so many patients, contributed to Bangura's misdiagnosis. But so too had Dr. Mahmood's egregious—though understandable, given the constraints and pressures he was under— diagnostic error. Bangura's family and friends ceremonially washed the corpse, having been told of Dr. Mahmood's diagnosis of a stroke—an explicit rejection of the mandates to leave all corpses to burial teams, even those thought to have died of something other than Ebola—but then, in a sense contradicting their confidence that Bangura had not had Ebola, called for the burial team and swabbers. This set of contingencies that led to Ndambie becoming a "hot-spot" seemed chaotic and not necessarily predictable, even while, it was clear, everyone in the town knew that Ebola was a proximate threat. With all the drama going on, the uncertainty, but also the ongoing and much more prevalent causes of death in the town (malaria, motorbike accidents, other infectious diseases, etc.), how could one know how to act in relation to these anxieties, prognoses of mortality, and the ongoing demands of life, sociality and care for the sick and dead? Ultimately, over 30 people contracted the disease in Ndambie, the names of the dead now displayed on a crumbling placard in the center of town.

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Yusuph took care of Pa Bangura when he was sick. He also attended the burial but said he did not touch body. A week or so after Bangura died, Yusuph felt joint pains and a headache. His wife rubbed leaves and local medicines on his body, and three days later, with only dry

symptoms, Yusuph hailed and took a motorbike to the hospital. The nurses at the holding center took his blood, and the next day sent him to Kenema with six others in the back of an ambulance. Several of the passengers were vomiting the entire way; everyone except for Yusuph ultimately died.

"Ahhhhhhh," Yusuph said, with his characteristic exaggerated screech. "That disease was *horrible!* Absolutely horrible." At Kenema, he was given only oral fluids and medicine to protect the foreign healthworker, no IV fluids for the dehydration. Soon after he was admitted to the Kenema unit, back in Ndambie, Yusuph's wife developed symptoms and was sent to Kenema as well. She called Yusuph later that week and said she was having diarrhea. She called again after Yusuph had been discharged to Kono to say that she felt she was getting better.

The following day, Yusuph said, he woke up and representatives from the DERC had already arrived and told the community that Yusuph's wife had died. Eventually, a nurse that had treated Yusuph in Kenema rang his phone. Yusuph quietly mimicked her soft, hesitant tone for me: "How are you? How are you feeling and doing? Sir, unfortunately the Madame passed last night."

Yusuph's nine-month-old infant also died. Yusuph insisted that the child must have contracted Ebola from her mother, but the timeline didn't seem to totally work out. By my calculations, it was more likely that she had also contracted it from Yusuph. I wondered if Yusuph suspected this horrific possibility as well. He made clear that he was aware of the risk—maybe even the inevitability—of contracting the disease after learning of Pa Bangura's swab results. When he spoke about asking his wife to rub the herbs to ease his pain, he looked conflicted, avoiding eye contact. There was silence for a few moments—it was almost like one

of those moments when one hears the expression *o, mɔtalman* — and then Yusuph mumbled as if to himself: "You see? No way to do."

*

Pa Bah was one of Yusuph's good friends, also very involved with the organizing of the survivors. He was a tall, elderly man with a deep voice. He had attended Fourah Bay college during a period of intense student activism; he studied Nkrumeh, and Qaddafi's Green Book and had to go into hiding for several months when his name ended up on the then-President's hit-list. After surviving Ebola, he was offered a job as a high-level staff in the community based programs division of a local NGO, and through that role, it seemed, he had developed a rather charismatic, performative air to the way he spoke about the disease and the work he did.

Pa Bah told me that he had contracted the virus from Christiana, the nurse who had taken care of the taxi driver. After the community heard the news that Pa Bangura had died of Ebola, Christiana had isolated herself immediately. But one day, Christiana decided to make what sounded like a walkabout through Koidu: to the bank, to the market, to the phone shop, to her friends—including Pa Bah. "I was skeptical," given the cluster of cases around Ndambie, he said, "But she said, 'I don't have Ebola!'"

Bah had clearly told this story many times before—how could he really have known where else Christiana had gone that day? I asked him what he thought she was thinking about, having been so diligent about isolating herself from her closest relatives but then strolling through Koidu. "Ebola…Ebola is confusing! Seriously! Let me tell you why—because we didn't have any experience with it before!" But Bah conceded—was he just saying this?-- that

Christiana had made a joke when she saw him, like, “If I die we all die!” Bah thought that since she was a medical practitioner, she may have been giving herself an infusion—or maybe paracetamol—to improve her symptoms so she could make the trip through town. “Honestly,” he said, “the only thing I noticed were that her eyes were red.”

Pa Bah said he got sick two days afterwards, then improved. Then he collapsed near the livestock market in town and went home and isolated himself. “At that time, the ambulance was an enemy, you know.” They treated you horribly, he said, and packed multiple people in ambulances at the same time, so if you did not have Ebola you might by the end of the trip. “I thought it was malaria, but when I vomited persistently I realized it is not malaria. I did not allow anyone to care for me.”

When Bah finally made it to the hospital, he initially refused to go to Kenema. “I had one option: death. And if I’m going to die I’d prefer to die in Kono so my family can at least know where my grave is.” But a Red Cross doctor talked him into going—that he had a chance to survive—and Bah went with eight people in the back of an ambulance. There was “no medicine, no water, nothing,” in the vehicle, and he said that five of his co-passengers died on the way.

Looking off into space, in thought, he shook his head. “Ebola….ahhh, Ebola is bullshit!” He seemed a bit melodramatic here, searching for the words to emphasize how bad it was. “Let me tell you, when I was in Kenema they gave me a piece of chicken,” he used his fingers to sketch a chicken drumstick, and smiled. “It was very nicely prepared. I thought it was a, a stick!”

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Over weeks, I traveled with Pa Bah and Yusuph getting to know the dozens of survivors in Ndambie. All of them had a clear narrative of where they had contracted the virus and what had happened once they left Ndambie, and not a single one mentioned the mop-up operation. In their trajectories and subsequent storytelling, the community healthworkers, soldiers, Chiefs and epidemiologists were not a noteworthy part. That whole spectacle seemed, as Jean Genet (2003) writes, "only a play acted," when really "the reality lay in people's daily lives; in silence, like translucency, punctuated by words and phrases" (6). The stoic, quiet tenor to my conversations with Yusuph and the others, at times punctuated by self-effacing humor recalling the precarity and abjection of the situation (like Pa Bah's chicken stick) was at odds with the stories of community resistance that I had heard from elsewhere, and the humanitarian incursion and local response I had witnessed in Freetown and Kono.

Many of those who fell ill with Ebola in Ndambie told me that they had delayed seeking care. One woman, Fanta, who lost her husband and two children, told me that well before the virus entered her family compound she had been terrified of Ebola. Every time she passed one of the Ebola checkpoints near her house she would tell her friends how afraid she was of the disease which seemed to be creeping towards the area. And yet, as her children sequentially fell ill, she kept them at home for three days before they were sent to the Treatment Center. She said it was not an issue of delayed ambulances or unresponsive hotlines—there were soldiers around, when they called the ambulance it came. But: "Some sick— you don't know it's Ebola, so you have to wait some time." She said that she "doubted" that her children had Ebola, she *didn't believe in Ebola* at the time. That phrase—one which sounded so much like the rumors I had heard back in 2015— was jarring to hear, but Fanta seemed to be describing less a refusal to consider the risk of the virus than temporality she had settled into at the time of "wait-and-see." Fanta cited her

own naivety and irresponsibility in not seeking care more promptly, but also seemed perplexed by the whole ordeal and how it had happened.

Many times, I had the sense that the survivors felt compelled to attribute the disease to their own choices: their doubt, denial, disbelief and refusal of the imperatives at the time to call for help rapidly and isolate those who seemed sick. But their stories of falling sick did not seem a set of discrete, calculating steps towards or away from the public health system. Rather, they fell ill, approached the fevers with a kind of quiet skepticism, a kind of waiting; those fevers turned worse, they made-do until someone decided that enough was enough, called the ambulance and they were whisked to Kenema.

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I recorded the stories of dozens of families and survivors: how they contracted the disease, what happened next, how their lives had changed. In these stories, there was no discernable pattern, overarching consistency or logic to how people fell ill in Ndambie, nor what they did afterwards. People cared for some friends and family members but shunned others. Symptomatic people isolated themselves from certain family members but not everyone. Some stayed home, hoping the sickness would pass or end up being malaria, but at a certain point made it to the hospital. Which households the virus entered and which it skirted around, and who within a household became ill, were not predictable. In these conversations, it was hard to tell what was memory, what was rumor, and what was an effort to impart to me and to others listening the arbitrariness of the whole situation.

For instance: one woman asked her whole family—including children—to care for her as she became increasingly sick, but then walked to the Village Chief to announce that she thought she had Ebola and needed an ambulance to the hospital.

Another: a teenage boy, I was told, fed up with quarantine, snuck one night into his girlfriend's quarantined house to have sex, and there contracted the disease.

A young, sick girl, I heard, was so terrified by the ambulance when it arrived at her family house, she ran into the bush. The ambulance men in their suits didn't want to run after her, so a neighbor ran to comfort her. The neighbor picked the girl up to bring her to the ambulance. He realized what he had done by picking up an Ebola patient—an *oh shit* moment—but did not know what else to do. He also contracted Ebola.

Every survivor emphasized the mercurial nature of how the disease spread and encountered their own bodies. Rife with contradictions, peoples' contacts seemed driven more by affects at quotidian registers of surprise, lust, foolishness, accident, loneliness, fear, love, piety, a desire-to-help-and-be-helped but also an awareness that there was "no way". It was well known that the Ebola care and treatment system was horrific; that "the doctors" themselves were making confusing and grave mistakes; that those operating the response apparatus treated affected people with disregard; that probably no good would come from immediately calling the hotline. People were discerning and realistic about what the actual possibilities for care were, and life went on, in all its tumultous normalcy.

Most troubling was that such ordinariness ended up meting out so much death: *A young man found himself sent to Kenema in an ambulance, returned home after testing negative, but didn't have a bedspread. He snuck around the back of a quarantined house where a patient had just been removed and retrieved the blanket. He then contracted Ebola and died.* That these

moments of contact spread the virus and death, when, of course, there were so many other bedspreads being shared, late-night rendezvous among teenagers, and unwell children in need of touch and care seemed so essentially arbitrary. The survivors I met often seemed at an impasse for language, trying as best they could to explain the way they had learned to relinquish control. And they often fell back on similar tropes of their own foolishness, ignorance, doubt and disbelief to those I had heard recounted in so many other spheres, perhaps because there was nothing else to say.

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"*I dɔn day, I dɔn day, I day." [He has died, she has died, he died.]* As I listened to these stories day after day, the individual deaths came to seem abstractions as they were counted on fingers, forgotten for a moment by survivors and kin and then remembered. I thought of a line from Michael Taussig, who, immersed stories of the atrocities in the Putamayo region of Colombia, wrote that "the unreal atmosphere of ordinariness [is] like watching a sunken world underwater" (Taussig, 39). Even the survivors' descriptions of the abjection they had experienced in the treatment center, vomiting blood, death all around them, horrible pain, were told with a haunting neutrality and objectivity, a chuckle here and there when I tried to acknowledge, pitifully, the tragedy of it all: "*that's horrible, my sympathies."* The sources of strength they recounted seemed almost impossibly simple, and often racialized: *"A white nurse there said you have to try to live, so I said 'Ok, I will live then.'"* While many survivors said that they thought they would die in the sweltering tents in the Kenema treatment center, not a single one told me that they were afraid of dying.

I wanted to read a politics in their stories—and in a sense, the survivors did, implicitly, indict a great of deal the impracticalities of the response and adhering to the "proper" health behaviors. But I was wary of imposing a kind of outward-facing critique in what seemed profoundly intimate and inward memories. Was this numbness? Fatigue of re-telling their experience? A "political economy of emotions" that constrained the registers through which their trauma could be experienced (Scheper-Hughes 1993)? A narrative form shaped over years of living in such proximity to demise, an insistence on the banality of these brushes with death? Echoes through a space of reverberation, between, on the one hand, the disease and its particularly torturous forms of transmission and death and one's inability to predict or warn of it, and, on the other, the excess on the part of the foreign healthworkers, armies, doctors, political leaders and Chiefs? The sense that life goes on punctuated by these brushes with political spectacle, illness and death—or else, it doesn't?

This is a place where death always hangs as a quotidian and proximate presence. Recall where this dissertation started, with the boy brushing his teeth in his compound, hit by the taxi and killed. In some ways, Ebola amplified this broader condition in which quotidian embodied practices—brushing teeth, washing a car, lifting up a child, borrowing a blanket—become, at particular moments that cannot be predicted, deadly. What can one do but hold these possibilities of living and dying close? There is no extricating oneself from the violence, no labor that can be done to repair a world by swallowing the memory of this moment of crisis when the event, the death, is indistinguishable from the everyday in its affective and embodied forms: when borrowing a blanket in November 2014 was ordinary, in December 2014 was deadly, and in January 2015 was again just ordinary.

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Christiana's walkabout has continued to fascinate me. This was the event that brought Ebola from peri-urban Ndambie into the heart of Koidu, even after Christiana, the nurse who had taken care of Pa Bangura, had so diligently protected her family and close relations. Her friends insisted: she did not need to leave the house. But this was a decision she made, one so contradictory it seems somehow recognizable, more idiosyncratic than disruptive or irresponsible or even calculating.

I return again to that space between spectator and spectacle conveyed through people's memories of humanitarian incursions. In certain moments, the landscape of political authority in Kono demands things out of ordinary people. It demands rumors and protest, or even violence and brutality. This landscape comes to bear on humanitarian crises and incursions, which themselves become enfolded into regimes of *commandement* and durable relations of postcolonial political authority. But *underneath*—I use this term intentionally, to invoke the long history of anthropological engagement with a cultural order of the region that is defined by suspicion, notions of secrecy, double-meanings, and intimate spaces held out of sight where the essence of intentions and life unfolds (Ferme 2001)—in places like Ndambie, there is an ongoingness to living, dying and care that seems unphased and perhaps untouched by the spectacle of crisis.

Perhaps this *underneath the crisis* is a knowledge that a contingency like Ebola will inevitably be managed by people and families—a pragmatic turning-inwards born of personal histories of engagements with, and disappointments of, politics and the humanitarian juggernaut. In other words, maybe these histories of serial spectacles that offer little in the way of care are

generative of a sense that ultimately one lives, falls ill and dies on one's own, with one's family and kin, out of sight. Perhaps the underneath may be thought a kind of resilience. Or perhaps it is borne of a familiarity with the proximity of illness and death, the ways these inevitable contingencies become enfolded into broader rhythms of life and relations to the future.

And so, for two weeks after hearing of Pa Bangura's positive swab, Christiana isolated herself. One day she just decided; "Enough," and left to see her friends and go to church. Maybe she felt guilty about it, maybe she tried not to think about it. Maybe she intuited that it would be the last time.

Chapter 5: Conjuring Global Health Security

I cracked open the door of the Kissibanga Clinic "Staff Quarters" where I had been sleeping; it was early and I did not want to wake whoever else might be around. I saw Tamba, the nurse, at his desk on the veranda of the clinic flanked on both sides by stacks of worn clinic registers. He looked up at me and chuckled: "Finally. I slept only two hours last night. I have been doing paperwork since 2AM."

Despite the overwhelming health needs of the people in this clinic's catchment area, Tamba's primary preoccupation, I learned, was with this paperwork. Tamba was recently assigned to Kissibanga clinic to initiate its upgrade from a Maternal and Child Health Post staffed only by a health-aide to a Maternal and Child Health Center staffed by him, a basic-level nurse. Local health officials' increased attention to this clinic, Tamba told me, was prompted by the fact that it was the last health outpost in Sierra Leone, in the remote region of the "Kissi Triangle" where the Ebola epidemic was thought to have emerged in December 2013. Tamba knew that the key to preventing another outbreak was in this paperwork. "If Ebola comes back, Kissibanga Village will be the first to know," he explained, referencing the omnipresent suspicion that the virus might now be lurking in the region's ecology. This lingering sense of threat was why the clinic needed a qualified nurse and the proper documentation systems in place—for, Tamba explained, data-collection is essential to preparedness. And in this context, with no electricity, communication systems or computers around, data was synonymous with paperwork.

To complete the upgrade, Tamba was cross checking every single record since 2014 in the clinic's registries. He scrutinized each scribbled patient record written by the Nurse-Aide who had previously run the clinic, considered the case, reviewed the diagnosis and plan, and

corrected the identified illness as well as the prescribed medications to what he thought they should be with his red pen. To craft a form of certainty, and perhaps to eliminate doubt about his own records, he then copied each line with a blue pen in a new register with the original (historical) date written on the front. Flummoxed not just by the fervor of his commitment but also by his palimpsestic re-inscriptions of new "facts" and diagnoses over earlier records, I asked if he was actually told to "re-write history" in this way. He told me that his revisiting and revising the past through its records was the proper way to do paperwork, and such "high-quality" data was what "national monitors and international data-collectors" expect out of a well-functioning and model clinic. And yet, no one had come to pick up the paperwork yet.

In this chapter, I delve more deeply into the logics and consequences of the latest illusory turn in the field of global health, towards Global Health Security. Tamba's idiosyncratic paperwork project serves as a useful starting point for an inquiry into a nexus of global health ideologies, bureaucratic logics, surveillance initiatives, and caregiving practices in the wake of Ebola. I explore how the turn to Global Health Security diverges in notable ways from prior regimes of humanitarian global health, but the overriding consequences are similar to those of behavior-change interventions, transient donations of piece-meal infrastructure, and the bureaucratization of neoliberal public health systems like that espoused by the Traditional Healers' Union: technocratic orientations mystify and circumvent the material sources of the population's ill-health, the region's poverty, and its vulnerability to future epidemic threats.

More specifically, here: I am interested in the ways that data generation and paperwork are now fetishized within post-Ebola global health regimes, Sierra Leonean health care bureaucracies, and local worlds of healing practice. I use the term *fetishize* specifically, to draw attention to the ways that paperwork and data-production are *prioritized* within post-Ebola global

health security regimes, but also to invoke the full analytic weight contained in that term as a key object of anthropological study: to argue that Tamba's endeavor to rewrite history—and the labor it entails—produced effects that might be called *magical*. Consider the resonance with a local healer just a short walk from Tamba's clinic, who uses his mastery of Arabic script and Islamic texts to confer forms of protection and power on those who merely come into contact with the writing.

I am curious, then, about how, in both international spheres and in Kissibanga alike, paperwork is invested with power beyond its materiality, both as a key to global health security itself and as a productive agent in Kissibanga's landscape of care. Building on a long history of ethnographic studies at the far reaches of the global health endeavor, I seek to explore how Tamba's mix of charismatic healing, biomedical *bricolage*, and text-based caregiving practice are at once a product of public health ideology, local cultural context, and overwhelming material constraints on his capacity to operate as a healer.

Tamba

My relationship with Tamba had begun several years prior. I met him in 2012 while staying at a rural clinic when studying the maternal health community healthworkers who were tasked with convincing women to deliver in facilities. I was impressed then by Tamba’s charisma and eagerness to demonstrate his clinical and managerial prowess. He seemed very attuned to the evolving politics and priorities in the health system, and had an ear to the ground for the stories and rumors unfolding in his catchment area. We had lost touch when the maternal health project had wound down. In fact, he had not believed the story that the project had wound down as a

product of the precarious whims of a philanthropically-funded micro-NGO, and had been absolutely enraged at what he saw as a conspiracy to re-direct the organization's resources away from him and his clinic.

Several years later, curious about what had happened to him and his thoughts on how clinical care and healthcare policy had shifted in the wake of Ebola, I tried to track him down. I had worried about him over the years; I often thought of his unflagging confidence in his medicine and himself, and I imagined that Tamba may have continued to practice in the clinic without proper supplies nor training during the peak of the Ebola epidemic. Many nurses stopped seeing patients during the epidemic given how many healthworkers contracted Ebola and how little supplies were available, but Tamba always was ambitious and striving to bring care to more and more patients. I was not sure if he had survived, or if he was one of the up to 21% of healthworkers in the country who had died of the disease (Government of Sierra Leone. 2015).

When I inquired with some former colleagues, one mentioned that Tamba had been stationed in the last clinic in Kono, on the border with Guinea, where the Kissi-speakers live. I wrote a letter and sent it with a motorbike heading off that direction, and woke up a couple of weeks later to a series of text messages: CALL ME NOW, TAMBA. We met at a small pharmacy at the edge of town. He had come to Koidu from his new clinic in Kissibanga to deliver a series of formally written complaint letters to the District Health Management Team detailing cross-border drug smuggling rings he claimed to have uncovered in his new village. He was very stressed with the amount of paperwork he had there, he told me, but he was happy. His new clinic was in the one Chiefdom in Kono where the population was largely Kissi, and Tamba was a Kissi himself. He invited me to visit him in his new clinic a few weeks later. After

stocking up sardines, Nescafe and biscuits, I set off with David for the four-hour motorbike journey towards the border with Guinea.

The clinic itself was built into a small hill surrounded by elephant grass; the rocky banks of the river dividing Sierra Leone from Guinea formed the eastern border of the village. This border area where Sierra Leone, Liberia and Guinea intersect is called the "Kissi Triangle" and is inhabited by Kissi-speaking people whose linguistic and social terrain extends into all three states. It is also where the Ebola virus is thought to have originally jumped to humans in December 2013 when (the story goes) a three-year-old Guinean child played with, or ate, an infected bat or fruit eaten by a bat (Saéz et al. 2014). Though Kissibanga did not have any Ebola cases itself, thousands died in surrounding communities as the disease spread, unnoticed and then uncontrolled, back and forth across the border. Under-resourced public clinics became nexuses of transmission, scores of health workers perished and many patients avoided the healthcare system entirely when it became known that febrile patients were being whisked away to far-off isolation centers for a near-certain and solitary death. Violence and community "resistance" to public health orders were widely reported during the height of the Kissi Triangle outbreak (Wilkinson and Fairhead 2017) and routine healthcare services largely shut down. The virus's rapid extension throughout Liberia, Sierra Leone and Guinea has been attributed to the regions' decentralized and siloed national health systems and the frequent cross-border movements of the Kissi-speaking people. Thus, in the wake of the outbreak, new public health priorities and funding streams proliferated across the region, seeking to alter the public healthcare system from a site for the provision of (materially constrained) care and therapeutics alone to one that can also surveil and mitigate the global threat of another emerging infectious disease epidemic.

Guillaume Lachenal (2015) notes that this is not the first time that the Kissi Triangle has been in the crosshairs of international public health regimes. During a 1940s Sleeping Sickness epidemic in the region, colonial health authorities faced similar social tensions, epidemiological dynamics and cross-border complexities. Lachenal's point is that the geo-political nature of this region has produced a "frontier ecology" that uniquely predisposes the Kissi Triangle to both microbiological and political crisis, such as during the Mano River Wars of the 1990s when hundreds of thousands of combatants and refugees traveled across porous borders among Sierra Leone, Liberia and Guinea. Given that the Ebola outbreak once again brought into clear view the epidemiological consequences of the region's neglected healthcare systems and unresolved issues of sovereignty and cross-border communication, recent reform efforts have sought to strengthen borders, monitor the movement of local inhabitants, surveil patients within clinics and generate new forms of data on the microbiological environment of the region and the care-seeking practices of its inhabitants.

The Clinic

Kissibanga Clinic consisted of five rooms. First, a waiting area: faded displays of dried grains and vegetables for educating pregnant women covered the dull wooden benches, and stacks of paperwork and exercise books were haphazardly scattered across desks and side tables. Second, a pharmacy store, usually locked and with meager supplies inside. Third, a room with two tattered cots for "inpatient care" that led to a separately divided space with a rusty metal obstetrics bed. Fourth, another storage room with a defunct radio system, and finally Tamba's office, a small space with an exam bed and vials, pill-bottles, American nursing textbooks from

the early 1990s and piles and piles of paperwork crowding all surfaces. Each room was plastered from floor to ceiling with public health posters—imploring people to sleep under mosquito nets, pregnant women to eat lots of meat, mothers to vaccinate their children; reporting that river blindness drugs are available in the capital city, that vaccines should be free and that there is a hotline if a patient is charged a bribe for treatment; instructing healthworkers on the correct process for burying an Ebola corpse (including proper "community and religious leader" involvement.) The clinic, like most in rural Sierra Leone, resembled something of an archive of the shifting projects and health messages that have been projected through it over the years. In the back veranda, Tamba had hired some carpenters to build a cage-like structure out of sticks that he said could be used as an isolation unit if a new Ebola case is identified.

When I reached Kissibanga, Tamba had just returned to the village from a four-week-long NGO training on a new emergency obstetrics algorithm and accompanying record-keeping systems. The clinic had not had a trained nurse present during that entire time, and was almost entirely stocked-out of antibiotics, anti-malarials and other routine medications as a result of inadequate national supply chain support. The following day, patients began to line up by 6 AM, many of whom had taken canoes from Guinea. Tamba sat at his table on the veranda, surrounded by stacks of clinic and notebooks registers, and I sat across from him surrounded by the drugs that are available and help him pack the pills into baggies. The majority of each encounter was spent recording the patient's name into four different clinic registers and translating the patient's complaints into medical terminology in the logbook. Tamba had a bottle of white-out near him in case any word was misspelled, or he deemed his handwriting too messy.

Tamba's preoccupation with paperwork even as he was treating patients made sense given his explanation for why he was assigned to Kissibanga. He explained that this was ordered

by UNICEF directly since they heard that such incompetent care and unacceptable recording practices were going on in this clinic and given the fact that Kissibanga will likely be the first to see the next Ebola case. Kissibanga clinic might be visited once a month by a District Health Management Team official for a brief supervisory call, but otherwise Tamba was only in contact with District-level authorities by written letter sent on motorbike. He showed me several letters he had sent requesting two nurse-aides with clinical experience to assist him. This, he told me, would enable him to sit at his desk all day and do paperwork—to complete the upgrade, to ensure that the new logs are properly in order as the nurse-aides report to him, and to make sure that Kissibanga never returns to the state of poor record-keeping that characterized the clinic before Ebola. Tamba's expertise was not wasted amidst the material shortages, he implied, but was put to good use in creating a meticulous register of what has transpired in Kissibanga in order to be prepared for an inevitably risky future.

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The capacity and impetus to generate statistics, demographic measurements, bio-informatics and forecasts, Foucault notes, is a key feature of contemporary biopolitical states (Foucault 2003). But the particular regimes of data-production that have proliferated within global health institutions are a product of a unique ideological and epistemological evolution. Many have noted that one of the key features that has defined the shift from international health to global health is the increased centrality of quantitative data production as a necessary component of health policy and programs (Erikson 2012; Crane 2013; Whyte 2014; Adams 2016). This data is collected and valorized in pursuit of a generalizable body of knowledge on implementing

effective health programs, and particularly relies on certain data markers deemed biological or social "universals" (i.e. diagnostic categories, therapeutics delivered, patient demographics).

In the wake of the Ebola epidemic, there has been another significant change in global health discourse and practice that has further entrenched certain forms of data-production as a foremost priority: that is, the increased centrality of *Global Health Security* within Sierra Leone's healthcare system. By Global Health Security, I mean a broad shift from conceiving of the healthcare system as a site primarily for the provision of care and therapeutics to instead a site for disease surveillance and threat mitigation. Medical anthropologists have noted the emerging centrality of "Global Health Security" in global health discourse and policy since the mid-2000s, vis-a-vis efforts to regulate flows of biotechnology, travel, military readiness and global health governance (Lakoff and Collier 2008). This shift was further codified in the 2014 Global Health Security Agenda, a United States-championed framework for guiding global health implementation that calls for increased focus on (and funding for) infectious disease surveillance and containment capacities within the Global South (Global Health Security Agenda 2019). But the broad and "epic failure" (Fidler 2015) of international health systems to prevent the West African Ebola outbreak from turning into a major crisis has definitively situated Global Health Security as a top priority for subsequent funding streams and health programs in Sierra Leone and beyond.

Andrew Lakoff (2008) characterizes one feature of the turn towards Global Health Security as a shift from disease *prevention* to disease *preparedness*. Within the domain of data-generation, we might think of this shift as from tracking therapeutics delivered and responded to—bednets dispensed, pills distributed, babies born, patients died—to the generation of massive amounts of information on the epidemiological and demographic characteristics of patient

populations. This also involves the proliferation of technologies of surveillance in order to identify and track emerging disease threats, but in practice this data has *not* necessarily translated into concrete, effective clinical practices to mitigate threat. Very often surveillance seems to be an end in and of itself.

When I returned to Kono for the first time since the epidemic, the shift from prevention to preparedness was visible in the offices of the District Health Management Team in Koidu City. For many years the building has been filled with sagging bookshelves stuffed randomly with clinic logbooks. Hand-drawn graphs on construction paper have been taped askew on the walls, showing the number of vaccines or deworming medications distributed in a particular month in a particular clinic. Now, the staff's doors were increasingly covered—from floor to ceiling—in high-resolution printed heat maps of 'real-time' disease events across the country. The World Health Organizational generated a weekly "Epi-Update Situation Report" with similar statistics, maps and epidemiological curves. Nobody within the District Health Management Team seemed quite sure where the data came from or what one was to do with it, but the aesthetics, systematicity and particular focus of the data had changed.

As a further indication that something different is happening to healthcare in the wake of Ebola, we might look at the $114 million—equivalent to nearly one-third of Sierra Leone's health expenditure—World Bank-funded Regional Disease Surveillance Systems Enhancement (REDISSE) program which aims to fund the Guinean and Sierra Leonean Ministries of Health to develop interoperable "community-level surveillance systems" in order to mitigate the fact that "The West Africa region is…a hotspot for emerging infectious disease... In this region, emerging and re-emerging diseases…are occurring with increased frequency." One young European man I spoke with in Freetown—one of the jack-of-all-trade development consultants types who

populate the beach cafes in Freetown—was particularly perturbed by REDISSE. He said that the scale of the funding was so overwhelming that some officials in the Ministry of Health had sought to negotiate some funds to go into projects that might also contribute to care infrastructure: blood banks, laboratories. But this was denied by the World Bank. The World Bank representatives were inflexible, the consultant said, and insisted that millions were going into vehicles and other useless activities. The consultant also noted that some of the surveillance funding was in the form of loans, but that, within the Ministries of Health and Finance, budgets and programs were so dependent on flows of donor resources that officials did not distinguish between grants and loan funding. Though Government officials were well aware of the illusory nature of these surveillance efforts in the context of the public health system's continued underfunding, and that loans would make the Sierra Leone Government further beholden to the stipulations of the international financial institutions, tens of millions of dollars would not be turned down.

This and other funding flows have triggered a rush among researchers and non-governmental organizations alike to generate new programs that wed implementation and data-generation about the microbiological characteristics of the region (World Bank n.d.). Much of the surveillance efforts in Sierra Leone revolved around building the country's Integrated Disease Surveillance and Response (IDSR) system. IDSR is a WHO–led framework for national health systems to identify priority diseases and collect surveillance information from all public clinics in the country and aggregate it in an Emergency Operations Center in the capital city each week. Sierra Leone's IDSR was nearly defunct for decades and its development has become a top priority for global health funders concerned about how long Ebola spread in the country without being detected.

Sierra Leone's IDSR now includes 26 diseases such as Ebola, Yellow Fever, and measles as well as polio and (eradicated) small pox. Nurses are supposed to tally up the number of patients they see each week who meet criteria for these diseases and report them to their district health management team. The vision of having data flow via a combination of weekly calls through candy-bar phones from every clinic in the country and uploaded spreadsheets from district capitals into a set of real-time graphs in an office in Freetown, led to an enormous array of epidemiological technocrats and data-support organizations offering their services in the region. A WHO lead in Freetown, for instance, told me that: "We first want a *system* where data is *flowing*". A CDC expert said they are working to "tweak the sensitivity of the surveillance system" in the wake of its failure in 2014, so that it will "pick up", "flag", "analyze" the epidemiological characteristics of rural populations. A high-ranking manager in a health analytics company that received a contract to digitalize the IDSR system told me, "A government needs some basic capacities to generate and manage data in order to advocate for itself." All of this language conjures a technocratic vision of the surveillance apparatus as something of a "vital system" on which collective life depends—like "the healthcare system," the "power system," the "water system"—one whose critical importance is questioned, and that needs to be cared for, monitored and optimized almost as if it is a living entity itself (Collier and Lakoff 2015).

But IDSR's lofty goals are belied by the fact that Ministry of Health officials admit that much of the data synthesized each week seems fabricated, nurses on-the-ground are unaware of the case criteria for many of the IDSR conditions, and it is not clear what type of epidemic event could only be identified by an epidemiologist in the capital city (rather than being immediately evident to clinicians on the ground). And amidst this all, the logistical and clinical infrastructure

that would be required to mount a substantive response to an outbreak in a place like Kissibanga should one be identified through the IDSR system remains woefully inadequate and under-funded (Kardas-Nelson and Frankfurter 2018).

Many non-governmental organizations in the country similarly oriented their agendas around disease surveillance, and now independently call healthworkers out of their clinics for trainings on new patient log-forms and handwritten surveillance regimes—some of which will feed into the IDSR system, and others which seem motivated by the current fervor to generate data and paperwork but which ultimately just accumulate. For instance: an International Rescue Committee program was developed during the Ebola outbreak to train local people to quietly text a code to an automated hotline when they observed a potential epidemic "event"—an unexplained death, a mysterious burial, a strange set of symptoms in a child—to generate a "real time" epidemiological platform (and digital panopticon of sorts) (Foucault 1995; Crowe et al. 2015). This "Community Event-Based Surveillance" is now being scaled up nationally by the Ministry of Health. The US Agency for International Development, the UK Department for International Development and the World Bank are also each funding new surveillance and Global Health Security portfolios worth hundreds of millions of dollars across the West African region (see, e.g. World Bank n.d.).

Global Health Security is not an entirely novel focus for global health institutions in Sierra Leone. In particular, Tulane University, the United States Military and other partners had been collaborating with the Sierra Leonean Ministry of Health for decades to generate epidemiological and microbiological data on another hemorrhagic fever similar to Ebola called Lassa Fever in the eastern city of Kenema (Viral Hemorrhagic Fever Consortium n.d.). But these activities, and this focus on mitigating infectious disease threat, were not widely institutionalized

in the country's public healthcare system at the time. As evidence of how marginal these efforts were before the Ebola outbreak: a 2006-2008 study by the Kenema team found that nearly 25% of patients in a hospital in southern Sierra Leone with undiagnosed febrile illnesses had serological evidence of exposure to Ebola, Rift Valley fever, Marburg or other extremely dangerous emerging diseases that, until then, were not thought to be circulating in this part of West Africa (Schoepp et al. 2014). Though there is debate about how these results should have been interpreted, no report was published until 2014, and there were no substantial reforms to clinical practice in Sierra Leone, changes in research agendas, calls put out to clinicians to be on the lookout for such diseases or other efforts to respond to this rather shocking discovery (that could possibly have staved off the subsequent Ebola outbreak). Such a history certainly demonstrates that data generated out of Global Health Security programs in Sierra Leone will not necessarily translate into substantive clinical improvements. It also shows that Global Health Security and clinical care delivery can be mutually-exclusive efforts. One is left wondering: for whom and to what end is data-generation being carried out within these Global Health Security regimes?

Even those domains of Global Health Security that require material investment rather than just technical data-collection seem overlooked. One time, at the District Health Management Team office in Koidu, I met a man named Gerald who introduced himself as the new District Infection Prevention and Control (IPC) officer. This was the domain of Global Health Security that depended the most on material supplies: disposable gloves and gowns, waste systems, incinerators. Since being trained by the World Health Organization, Gerald said, there had been no funding. In an almost baleful tone, he told me that he found this neglect of infection control particularly egregious, "Since IPC cuts across all walks of life and health." While

REDISSE bikes tagged for disease surveillance lined the parking lot, for his own activities Gerald said he had not been given a bike, fuel or vehicles—let alone infection control supplies. He sat around waiting to see if he could tag a ride with others from other departments, so he could go out into the field to monitor clinics' adherence to infection control protocols. But this seemed more of a hypothetical; it was unclear whether this ever happened, or if he just sat in his empty office every day waiting for funds to come. "I want to go to the field, but I can't. There's no secret about it," he said. In the clinics there were no gloves or liquid soap. At the hospital, he said there was no "placenta pit," no waste management bins, no decontamination system for the ambulances—the British aid agency had stopped all that funding. I asked about REDISSE. He shook his head, frowned: "REDISSE gives nothing for IPC. Surveillance is getting everything, bikes, vehicles, fuel, everything."

Back in Kissibanga, Tamba knew that the key to tracking and preventing the threat of another outbreak lay in generating data. He had spent months in training on the new data collection forms; the workshops he spent so much time attending redefined and reinforced his new role as a critical sentry on the lookout for emerging disease. Tamba's certainty that "if Ebola comes back, Kissibanga Village would be the first to know," compelled him to prepare; the village's health security would be ensured with robust data on the patients who came to his clinic, where they came from and what symptoms they displayed. Armed with only a pen and dozens of logbooks, Tamba, was, in many ways, engaged in a project no different from that of the Ministry of Health, the World Health Organization and the scores of NGOs, data management companies, consultants and health security experts surveilling the Kissi Triangle and the threatening viral ecology therein: robust data is Global Health Security.

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At every break and after the last patient had been seen Tamba returned to his primary paperwork project: poring through the records from years past, identifying what he deemed inappropriate practice, and re-writing the record to his specification in the replacement log. The logbooks were horizontal, 1.5 feet long stacks of paper bound with duct tape and two pieces of card-stock. Each page had an identical long, spread-sheet like grid printed on it. The General Clinic Registry had the following columns: Serial and Registration number (left blank for each patient—it was unclear where these are supposed to come from)—followed by the Date; Name; Age; Sex; Occupation (nearly always Farmer or "H/W"—Housewife); Previous and Current Address (always the village name); Diagnosis; Date of Onset; Treatment; a series of checkboxes to designate if they have HIV, TB or fit into other "vulnerable" categories.

When Tamba got down to his work revisiting past records, he would ask the clinic's Porter and Vaccinator to clear off the stethoscopes, vials, pill-bottles, syringe-boxes and malaria tests from his table. He meticulously laid the clinic logbook from 2014 to his left; the new logbook went to the right. He then studied each record. Every single line was transcribed into the new, clean book. Most of his adjustments to the historical records centered on the sloppiness of the paperwork itself—illegible handwriting and crossed-out treatment prescriptions. So if, for instance, he could read from the old Aide's log that a 47-year-old farmer named Komba Nyomah from Guinea complained on December 7, 2014 of a distended abdomen, diarrhea, chronic abdominal pain and loss of appetite, but cannot discern the diagnosis and treatment because of sloppy script, he might cross out the Aide's blue-ink writing and use his red pen to write over her scribbles in the diagnosis column 1) PEPTIC ULCER DISEASE; 2) INTESTINAL PARASITE

INFECTION. He would then transcribe, in blue pen, the entire row (only including his own diagnoses, of course) in the new logbook.

Several times, he called me over, ticked his tongue and said: “See? See the irresponsible state this clinic was in?” In one case, he made a big red ‘x’ over the aide’s blue ink calling for a prescription of Artesunate/Amodioquine for a young pregnant woman with malaria. This was not acceptable for a pregnant woman, he said, and wrote in red: “Fansidar”, the name of the chewable tablets given as part of antenatal malaria prophylaxis. He then copied the corrected row into his new logbook in blue ink. Sometimes, he could only read the treatment, not the diagnosis, and he had a method of working backwards to straighten out the record by taking into account demographic information about the patient. For instance, I asked why he revised so many diagnosis records to say “Chlamydia/Gonorrhea complex” when he could not read the prior nurse-aide’s diagnoses. He told me confidently that 90% of young Kissi people in this area were infected with “subacute” sexually transmitted infections as a result of their promiscuity. Though Tamba’s dismissive tone suggested that this was more a condemnation of his rural patients’ assumed behaviors than a neutral clinical observation, such moral valuations (or “local knowledge”) inflecting health data is not rare but is in fact constitutive of many types of data—especially those involving patient diagnoses. Such data may claim to represent the “raw” world simply transferred to the page, but this is a fiction; such data is in fact always entangled with social relations and contexts, constituted through serial interpretations and “cleaning” as it is generated, analyzed and circulated within and beyond the field in which it is produced (Crystal Biruk 2018).

The newly created logbooks were legible and pristine. His handwriting, a mixture of cursive and stilted block, was only punctuated by white-out blots where his hand slipped, and

large, circled numbers that he used to delineate multiple complaints, diagnoses and treatments within one spreadsheet cell. Those around Tamba—the Traditional Birth Attendants, the Vaccinator, Porter, and patients—seemed to note his paperwork with nothing short of reverence. "He's ambitious," I heard those in the clinic frequently say. "We're really grateful to have him here." Tamba, for his part, said he likes remote villages like Kissibanga not only because of the seriousness of the task at hand but because they enable him to "reach and perform at my full potential."

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The fact that an educated healthworker could have attended weeks of training on these new documentation systems and returned to his clinic to spend the majority of time filling in historical records, in fact, will never be passed on to higher level officials brings into sharp relief the risks of data-generation further displacing clinical care as the primary purpose of a post-Ebola healthcare system. A painful irony underlay Tamba's meticulous work: history has shown that it takes a global health crisis in order to mobilize the humanitarian juggernaut in places like the Kissi Triangle. And yet, Tamba, like everyone, knew that *good data* was key to preparedness —especially in the African context in which, as one prominent development economist has noted, data are often simply too tainted by material constraints and untrained enumerators and "too poor for their purpose" (Jerven 2013:7) to substantively inform policy. And yet for Tamba, *good data* meant more than empirical purity. It should also signify something "good." His records would paint a picture (to a "national monitor or international data collector") of a fully stocked and highly-organized clinic that might actually be able to identify and address an emerging infectious disease epidemic.

I am reminded of Levi-Strauss's famous vignette "A Writing Lesson," in which a Nambikwara chief publicly imitates the anthropologist's scribbling in front of his subordinates with his own squiggly lines. Levi-Strauss draws attention to the fact that the performance of writing amidst illiteracy and an emergent written bureaucratic order can simultaneously sediment forms of authority (and portend violence and domination) but also convey an aspect of play and of parody (Levi-Strauss 1981:296). One might thus interpret Tamba's paperwork project (unfolding in a barely stocked clinic) and the sheer hours he was expending in pursuit of this (mis)-understood goal as something of an absurd—if unwitting—satire of the fetishization of data-generation within contemporary Global Health Security regimes. After all, Tamba was merely enacting (with great zeal) current global health practices and priorities.

There was certainly something important about the temporal characteristics of Tamba's work, and its reconceiving the past-as-written into a domain of intervention. Michael Jackson nods to a resonant culturally-ordered temporality among the Kuranko people of northern Sierra Leone. As described in Chapter 3, rather than emphasizing the lingering effects of past traumas, historically stable particularities or intractable poverty that constrain lives and life-chances, Jackson writes that for the Kuranko "it is how one bears the burden of life that matters, how one endures the situation in which one finds oneself thrown" (Jackson 2011:61). In this sense, Tamba's reformulating a chaotic and troubled past into a managed and endurable history might reflect a sort of making-the-most out of his condition and constraints. Drugs and diagnostics may have been in short supply, but paper was ever abundant. These possibilities draw attention to the ways in which proliferating data-collection regimes are shaped by culturally-ordered epistemic systems as well as harsh material conditions on the ground. In the process, the knowledge that is

recorded is at once revealing and generative, but is also unanticipated and, to some extent, at odds with the stated objectives of epidemiological data-collection.

Such temporal interventions also have a certain resonance with the "epistemic orientation towards the future" characteristic of the current moment of ever-proliferating and promising techno-interventions (Adams, Murphy, and Clarke 2009). This is a mode of relating to a future in which the record keepers may come, in which another Ebola outbreak might emerge with donors and resources and interventions in need of a model clinic to invest in, a future in which Tamba's ambition and clinical and record-keeping prowess may finally be recognized and buttressed with the resources and technology needed for him to reach his full potential. One could argue that Tamba's work to revise the past records was not so much an effort to re-write history as it was to dissect, analyze, "clean" historical surveillance to provision a better preparedness map for the future.

In many ways, this future-oriented temporality parallels that which characterizes norms of Global Health Security that lead to an ever-greater amount of data-production in rapid sequence—an "anticipatory knowledge" that approaches the "real-time"—in some sort of Sisyphean effort to "imagine" and then to prepare for unprecedented threats (and contingencies therein) that cannot actually be identified or named before they happen (Lakoff 2008:401). In the process, the work of actually *preventing* an outbreak by drawing on historical experience to guide material investment in infection control systems (or attending to the political-economic etiologies of inequities and epidemics) is obscured through technocratic, imaginative exercise (Lakoff and Collier 2012). Thus, we might further characterize the shift identified by Lakoff from health *prevention* to Global Health Security *preparedness* as a shift from an inductive, empirical and scientific epistemology to a type of soothsaying, a type of magic.

If data-generation *is* Global Health Security within these global health regimes, then what exactly is *the global health secure* around which all this data is circling? An elusive state of ultimate ecological and patho-physiological control that can be conjured through an apotropaic proliferation of heat maps and epi-curves in their materialities? The capacity to ward-off a future catastrophe before it can even be wholly imagined through the production of endless data-points? The power amassed through the accumulation of numbers upon numbers of surveilled patients, with no capacity to act upon what these numbers reveal—in Michael Taussig's words, the "signifier peel[ed] off from [the] signified" (Taussig 1992:128) and invested with its own magic and significance? Is this not the very definition of a *fetish*? In the first text to introduce the term *fetish* to a European audience, Charles de Brosses wrote in 1760: "While…passions hold [man] suspended in the anxiety given to him by the uncertainty of future events that he can neither know nor control, his imagination works to form an idea of certain powers higher than his own and capable of doing what he cannot" (de Brosses 2017:110). He continued:

> The worship…of certain terrestrial and material objects [is] called Fetishes by the African Negroes…for that reason I will call it *Fetishism.* …I plan to use it equally in speaking of any nation whatsoever, where the objects of worship are…inanimate beings that are divinized…[and] for whom objects of this sort are not so much Gods, properly speaking, as they are things endowed with a divine virtue: oracles, amulets, and protective talismans (45).

The concept of the fetish was taken up in continental philosophy, economics, psychoanalysis, critical theory, comparative religion—all while remaining a central focus of study for Africanist anthropology (Morris and Leonard 2017). The term *fetish* has a life of its own in Sierra Leone: traditional healers speak ambivalently of the "evil fetish practice" they combat through the use of their own fetishes, and the Sierra Leone Sorcery and Fangay Act of 1965 seeks to regulate the use of such magical implements. And there is a long history to the fetish being tied to written

text within the Kissi Triangle—even if, in Tamba's clinic, the type of paperwork and what was written was novel.

A quarter mile stroll from Tamba's clinic, in the cluster of mud huts that flanks the Kissibanga Chief's house, Abu, a young and affable man, performed his own magic. In Abu's one-room hut, with only a bed, a prayer mat and chalkboard inside, he told me about himself.

> You bring your problem to me... You explain to me if it's a devil, or a witchman who follows you. I am able to understand that through the Quran… When you give me the *kola* [payment] I look through the Quran, I write something… just like I write on that board, I wash it [the chalk on the board], I give [the liquid] to you to drink, you rub it on yourself, and you go.

Abu said he can cure ordinary sicknesses, like impotence, or even marital conflict. I inquired where he learned this work, and he said a man from Guinea taught six people in Kissibanga how to write the Quran years ago, but only Abu had the gift of turning his literacy into magic.

> All this I take from the Quran—it's a gift. If I were to tell you I mixed herbs from the forest, that would be a lie. It's all from the Quran…I sit down and I write it. On the board. I write it, and then I wash it. When I wash it, I take the water, take a container, open it, put the water inside. And you go with it.

I asked how he knows which Quranic verse to use for each patient. "Well that's what I've learned!" The knowledge of how to write—how to spell, how to read, how to organize a *Surah*, how to scribe calligraphy on a board in a pattern, to turn it into a power that neither his patients nor his colleagues nor an anthropologist can fully understand—that was Abu's authority, his efficacy, his magic.

Abu's particular mode of fetish-making—of harnessing the written words of the Quran into a potent magical substance—is found throughout Muslim Africa (El-Tom 1985). This form of magical healing is thought to have been brought to Sierra Leone in the 19th century as literate Mandinko, Susa and Fula *marabouts* (holy men) migrated into the Sierra Leone hinterlands. "The arrival of the marabouts did not basically alter the belief of the Temne [a central Sierra

Leonean tribe] in the power of charms," one Sierra Leonean linguist notes. "If anything, the marabouts had everything to gain by not discouraging those beliefs, merely replacing the forms of divining and charms by new ones based on the Koran" (Turay, in Skinner 1978:58). In this regard, the *fetish*-ization of Arabic text into a magical substance was deeply syncretistic, "a key function in the integration of Islam," and, with it, Arabic literacy, "with traditional culture" (Skinner 1978:58).

These practices of magical healing through written words are not merely spontaneously-arising out of a cultural order of superstition and secrecy but have also emerged out of and in relationship to histories of scarcity, violence and political collapse (Ferme 2001). Indeed, given the 56.7% illiteracy rate in Sierra Leone (UNICEF 2013)—likely much higher in rural areas like the Kissi Triangle—the knowledge of how to write and read has long been entangled with ambivalent notions of power, authority, sorcery and secrecy. Historically, those who knew how to write in Arabic had migrated from the Imamate of the Futa Jallon in today's Guinea, or had trained with Mandinko or Fula scholars with connections to North Africa. Those who knew how to write English had likely learned far off in a major city at a colonial school. A 1986 ethnography of Arabic literacy and its relationship to secrecy among the Mende of Sierra Leone notes that, "The Mende believe that foreigners often carry powerful outside knowledge, which can entail considerable prestige (and suspicion)" (Bledsoe and Robey 1986:209). The magic of writing and those who can write historically emerged both from its exclusivity amidst illiteracy and its embedded links to this alterity.

Enter Tamba, the ambitious nurse from the district capital with his extensive training in and performance of paperwork-production. Visually, the intricate Quranic calligraphy written in organized sequence on a healer's tablet before it is washed bore a striking resemblance to a page

from Tamba's clinic log. In the context of material constraints that limit health workers' possibilities for clinical practice, Susan Whyte notes that medical paperwork in Ugandan clinics "demonstrate[s] the superior knowledge and authority of the health worker…. the tangible performance of formal healthcare" (Whyte 2011:35). It is awe-inspiring to see an expertly filled log-book, just as it is awe-inspiring to witness a Quranic code covering a tablet.

But as Whyte points out, there are multiple processes at play when a medical form is being filled: a substantive inscription of *knowledge* (to be re-visited and to produce a form of accountability), and a more performative quality of writing-as-labor. Whyte references Ugandan funerary practices in which, she says, the names of those who contribute money to the deceased's family are inscribed on exercise books but do not circulate anywhere afterwards. Like Tamba's logbooks, nobody seemed to look at these names again. Whyte argues that what is at stake is a "substantial performance of writing" (Whyte 2011:36). This was true of Tamba's paperwork project too, but there was something more going on than simply *performance* in Kissibanga clinic. While raw data (in its materiality as paperwork) that sat untouched in a remote Sierra Leonean clinic might be considered powerless to a health systems development expert, within Kissibanga clinic it was precisely the accumulation of this paperwork that made it act through magic, as if a fetish.

In summary: one can certainly read Tamba's paperwork project as corrupting data, wasting time, or substituting for "actual" medical treatment in an empty clinic. But there was also something relational and affirmational about this exchange of patient names for expert inscriptions. Amidst bare pharmacy shelves, Tamba's knowledge and production of intricate paperwork were precisely what defined him as a healer distinct from other men and qualified with a therapeutic authority. The links between these record-making exercises and the protection

they were supposed to confer on patients—their *efficacy*—were not clear. And yet the paperwork was taken as a fulfilling and powerful form of care—for the patients kept coming, kept reaffirming Tamba's authority and his magic.

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Any healer who blurs the line separating the mundane and magical through the use of fetish-objects is ambiguous, risky and dangerous (Levi-Strauss 1974). People in the Kissi Triangle were both dependent on and wary of the power of healers like Abu and the very fact that Abu's healing practice confronted and dealt with witches, dark magic and sorcery. The most fervently religious Muslims might not have gone near a healer like Abu, for they did not want their presence to contribute to or bolster Abu's engagement with sorcery. Others in the village might have sought Abu's care in a state of desperation if they faced a severe illness or curse, but even then would express discomfort that they could not find another way to address their problems.

What, then, are we to make of Tamba's fetish-power under conditions of biosecuritization—particularly in relation to the ambiguous position other forms of text-based healing hold in the Kissi Triangle? Was Tamba merely appropriating patients' names to buttress his own authority, concealing the fact that his medicine cupboards remained empty? Could such paperwork be an inevitable result of an outbreak preparedness strategy that so fetishizes surveillance as Global Health Security itself? In other words: for those experts for whom the health and strength of the *surveillance* system has become the ultimate object of Global Health Security efforts, is there any impetus not to let another epidemic play out in order to record ever greater numbers of data points? I am certainly not arguing that there is a causal link between

West African text-based healing practices and the apotropaic power of Global Health Security data amidst empty clinic shelves. But an ethnographic engagement with the former—and an attention to the risks revealed— can help theorize Global Health Security and its perilous underlying logics. That is, data-laden paperwork may at once conjure certain semblances of control and forms of what might be called a magical epidemiological security while obscuring other enduring threats. There is a lot of care invested in the materiality of paperwork—and a complacent comfort engendered through the power of its production and accumulation— that could be invested in something else material: the clinical infrastructure, training and infection control supplies that have actually staved off outbreaks in the past (Farmer 2014). With these material interventions absent, with the structural once again mystified and left in-tact, Tamba's Kissi patients continue to face capricious illness and vulnerability to epidemic threats, with little available in the way of care.

In this sense, there might be another, unanticipated endeavor yet motivating the scores of patients who traveled to Tamba's clinic to have their names written down. In their paper on the introduction of literacy to Mende-land in Sierra Leone, Bledsoe and Robey note that "Many Mende insist that they... do not need writing to help them remember important things. Instead, they value writing more as a skill that can support the legitimacy of claims with respect to prestigious, literate audiences" (1986:204). Who might these imagined prestigious and literate audiences have been for Tamba's patients? Just like in humanitarian crises past, his patients had seen the region temporarily flooded with responding organizations and healthworkers— a transient target of global concern and material care that shifted away as rapidly as it had come when the outbreak was deemed over. Now, there could be differential hopes among those who traversed borders and rivers to seek Tamba's care. Many hoped for drugs; most knew there are

few to be found in Tamba's clinic. This is the nature of Kissibanga's "projectified" (White et al. 2013) landscape of healthcare. Together, Tamba and his patients were crafting a set of logbooks—a history, an archive that staked a claim to legitimacy through its meticulous scripts: *this is who came to Kissibanga clinic for treatment; and these were their ailments.* To this end, then, we might consider what the national monitors and international data collectors could do with this record, if they ever show up again.

Chapter 6: Tamba's Medicine

During my time at Kissibanga Clinic, I could always tell when a child had died in in the village because of the wails that followed. The sound awakened me in the middle of the night, even before, half asleep, I could make out what it was: such an unsettling pitch above the treefrogs and the wind rustling the elephant grass that bordered the staff quarters. First, a distant moan, then, like an ambulance siren undergoing the doppler effect, louder and higher as the throng of women ran closer to and then rushed by the clinic. The wails grew in volume and cacophony as others awakened and joined.

The morning after the death, the wails often felt like distant dreams. No one spoke about them at the clinic. But Tamba and his nurse-aide Mabinty, the clinic's Vaccinator and Porter always knew the story if I asked. One morning after a night punctuated by such wails, I inquired about what had happened to the child. Tamba, seated at his table, told me without pause that the baby was crying a bit, and fiteen minutes later, was dead. I asked what he thought the cause could have been. He took a pensive breath and leaned back, tapping his pen against his lips, as if formulating a differential diagnosis. "At this time of year, probably spiritual manipulation." It was most likely an "in-house" deal, he said, a debt that the mother had to pay her witch peers since it was getting to be August, deep in the rainy season, when cash reserves ran low and families began to be desperate for food. "There are these witch co-ops, you know," he explained. "Like a rotating credit system, except you have to give up the baby as collateral." I had heard of these witch arrangements before, one of many occult formations that are spoken about throughout Kono and the continent more broadly that draw out the resonances between extractive market logics and occult anxieties. In this case, Tamba explained, the witches had

their own *osusu*, a rotating credit system that many women partake in in Sierra Leonean villages like Kissibanga.

During the days, Tamba worked hard to craft his clinic into what a "Center of Excellence." During breaks and at night, he stayed up late working on paperwork and monitoring the patients he had admitted. But at every opportunity, it seemed, Tamba attributed his patients' and the villagers' misfortunes and illnesses to their own behaviors. Many times, as in the case of this baby who died, Tamba blamed the death on the parents' practices of sorcery or witchcraft, but just as often he accused them of improper hygiene, poor health behaviors, lack of education. Infants have worms, he told me, because of poor prenatal care. A baby's colic was because of mothers' pool nipple hygiene: sweat comes down and makes blockages in the nipples. The rural villagers' taste for worm-infested catfish led to "large infestations" in every adult. Women just wanted pills, not to take care of their children. "Any woman who begins sexual activity before puberty, there is the possibility the breast development will become stunted…and once they come [to the clinic for their malnourished baby] they create a situation in which you *must* give them drugs," he told me of one woman with a young child who had come for treatment. On a walk through the village, we once ran into a young woman holding a large baby covered in lumps and sores on its head and back. Tamba told me that the baby had long had an abscess problem, but the mother "didn't finish antibiotics because she's irresponsible. [And this outbreak] must be some toxin" that the baby had been fed by the irresponsible family.

I often wondered whether these asides about his patients' self-destructive behaviors were Tamba's effort to match what he assumed was my own perspectives on the ubiquity of illness and death in the village; as if I, like the many public health experts who had delivered workshops he had attended, was inclined to read all of this illness through the lens of "behavior change" and

"need for sensitization" and other denigrating stereotypes about ignorant villagers. But Tamba's relationship to the surrounding villagers was different than those conveyed by the behavior-change experts I had come across in Koidu and Freetown. Tamba's castigation was less patronizing, condescending, optimistic, and more paranoid and precarious. His supremacy as a clinician and as a representative of what he thought of as Modern Medicine in the village was not to be taken for granted, for there were also insurgent occult forces at play that threatened him, his grip on reality and as a broker of matters of life and death. Tamba always seemed on edge, his days in the village colored by nervousness and unease. The constellation of nervous affects at play in Kissibanga Clinic were perhaps more akin to that which historian Nancy Rose Hunt argues characterized public health regimes on the peripheries of unstable empire in the Belgian Congo, rather than the nihilistic and patronizing orientations that typically characterize contemporary global health programs and practitioners (Hunt 2016).

After one long day of observing Tamba at work, I was feeling exhausted and a bit queasy at witnessing such terrible illnesses juxtaposed with Tamba's constant blaming chatter. "Can I just ask you," I said, "what made you decide that ultimately every one of these patients is sick because of their own bad behavior?"

"Well, not bad behavior itself … if I could say so, it's based on their level of ignorance."

"Sure, ok, but [you are saying that] still the problem is with them, not with the poverty nor with the social conditions here," I added.

"No. All are connected."

"But my question is: as a clinician, when did you start realizing that actually most patients are just sick because they're ignorant?"

"It's not a… let me say, *perspectual* blame. But it's a way of, you know, telling them that they have a responsibility in … the welfare and the health of themselves and their children." Here, he sounded like a classic global health technocrat, and I was getting a bit carried away.

"But instead of saying, you know, 'It's a shame that fourteen-year-olds are all getting married because they have an ignorant tradition here,' you [might] say, 'Why does it make sense to the fourteen-year-old to get married?' And then you might open up more interesting questions than [this constant] condemning everyone, all the time."

"Yeah, well, it's not condemn per se, the way I see it. The way I see it, this is a community that is *absolutely blind to this idea of coming to hospital*."

I did not know what to make of this. I had seen dozens of patients come each day to Tamba's clinic, often from great distances. He constantly gloated of the number of patients that kept him in his office late into the night, monitoring drug administrations and working on the endless backlog of paperwork. And yet, there it was: Tamba had reiterated that assumption, that causal claim, embedded in so many global health interventions that had saturated Kissibanga and Kono over the years: *people need to be taught to come to the clinic, to want to live, when they are sick.* But here, Tamba had twisted it, had shifted its insinuations from what I was used to. In the context of his paranoid musings, the community's "blindness" to the clinic seemed less a matter of sick patients' impassivity towards medical care or even death, and more, perhaps, one of resistance, insurgency; an active shunning of the clinic in favor of their sorcery, hedonism, promiscuity. Tamba's job here was to mitigate and intervene upon this community, rife with backwardness and occult activity in addition to offering medicines; in this sense, he seemed a practitioner of the social as much as of the clinical.

In this chapter, I further explore the nature of Tamba's medicine and the clinical, affective and social dimensions that constituted Kissibanga clinic. I draw on fieldwork from 2017, when I recorded and explored his paperwork project, and 2018, after his initial "paperwork project" revising past logbooks was complete. In so doing, I pursue, somewhat orthogonally, Tamba's enigmatic characterization of Kissibanga village as "blind to this idea of coming to the clinic." *What,* exactly, was the "idea of coming to hospital" to which he referred? What were patients leaving when they withdrew or avoided the clinic entirely? What was the nature of the care that Tamba offered?

Much has been written in recent decades about the nature of care in Africa's resource-constrained clinical spaces. Some scholars elucidate the challenges that African clinicians face as they try to deliver effective medical care in the contexts of overwhelming scarcity (Farmer 2001; Farmer 2004; Farmer 2020; Richardson 2020), beckoning "intervention" via more resources pumped through cash-strapped clinics and hospitals. Others redirect attention from the impoverishment of public health systems and towards the intenguities, local knowledges and material, intellectual and affective plasticities that define clinicians' work as they make-do and offer that "which is nonetheless there, beneath the surface: *care"* (Livingston, 6). In these texts, "care" remains a somewhat undefined, if also untroubled and valorized, shared telos of (resource-constrained) medicine. Yet another body of literature focuses on the experiences of healthworkers as they navigate their own positionalities, aspirations and senses of expertise amidst the global flows of medical personnel, culture, donor funds and global health programs (Wendland 2012). African clinical spaces today are sites in which volunteer clinicians come from far away to bestow expertise and often breathlessly offer "answers" to complex social and economic problems that endure (Wendland 2010); in which hospital administrators must

navigate transient economies of humanitarian affects, expertise and resources in order to bolster healthcare capacity (Crane 2013b; Sullivan 2020); and in which trainees and hard-working local staff must assimilate these economies into their own "moral maps and medical imaginaries" and thus identities as practitioners of medicine (Wendland 2012). Scholars have highlighted the displacements of local personnel and realities amidst the simplistic politics of humanitarian "voluntourism," the "dreams" conjured and pursued in clinical spaces laden with transnational networks of funding for, expertise in, and imaginaries of care (Geissler and Tousignant 2020). In these para-institutional voids of resources, medical practice may take on whole new valences, politics and entanglements into local moral and social worlds (Kleinman 1989; Whyte 2014b; Geissler 2015).

This chapter follows most closely this last line of inquiry. Ethnographic immersions in rural clinics like Kissibanga consistently bring into view complex social, cultural and epistemic frictions in the day-to-day practices and possibilities of care. In these facilities, healthworkers like Tamba are integrated into local social life and landscapes of healing. Diverse healers, birth attendants, religious practitioners and sodality heads come in and out of these porous and plural health posts. Social tensions emergent from the nearby village come to manifest in staffing arrangements and relations of care, and diverse notions of etiology and occult anxieties come to be entangled with—and at times confound— the dominant ideologies of neoliberal global health: behavioralism, experimentality, cost-effectiveness and "sustainability."

Medicine—even modern, "Western" biomedicine—is not a universal set of practices that are simply replicated the world over. Likewise, "care" –a "sociality based on incommensurate experience" (Garcia 2010:50)— cannot be taken for granted or entombed as a relation of presence, empathy, or healing with a singular object. In other words, Sierra Leonean clinic as a

field or stage in which the economic, the social, the affective, the interpersonal, the cultural and political forces intersect with bodies, illness, notions of causality and plural orientations towards care: something of a "total social fact" as Marcell Mauss would have it (Mauss 2000).

Here, I am interested in pursuing questions such as: How do medical technologies become enfolded, as polysemic objects, into broader landscapes of material culture? How do the affects and imaginaries of neoliberal global health funding reach their audiences in rural clinics like Kissibanga? And if, as I came to suspect, the forms of care delivered out of Tamba's clinic often do not save patients' lives or improve their health –a tacit knowledge that permeates beneath the surface of Tamba's practice and his patients' experiences of illness and healthcare – what might way say about Tamba's patients' continued demands for his care?

The chapter is organized into two sections. First, I consider Tamba's personal history, the interpersonal dynamic and tensions in the clinic, and the ways both his recollections of his own biography and lineage and his relations with colleagues are entangled with the logics and imaginaries of both global health and the occult. Second, I zoom in on Tamba's clinical practices and relations with patients: the logics and il-logics that drive them, the structures and rhythms they adhere to (and the imaginaries and politics those structures reflect), the ways they fit into broader landscapes of charismatic healing and bureaucratic disregard while still allowing space for Tamba's own therapeutic agency. I consider whether a notion of the "effectiveness" of Tamba's medicine (and the rich anthropological literature that that term evokes) adequate to capture the fragility of Tamba's position, and the "stochasticity" (that is, the unpredictability at a granular level) of his patients' outcomes.

I must preface: the stories and practices recounted below are in some ways very singular to Kissibanga's clinic, Tamba and his own idiosyncrasies. Even within Kono's health system,

Tamba was a controversial figure. Once, I mentioned his name at the District Health Management Team office in Koidu and almost as a reflex one of the bureaucrats muttered under his breath "*no-team-spirit-delusions-of-grandeur"* and then told me that they would soon be moving Tamba's post to the District hospital, where they send the nurses who think they have gotten too "big." (This never happened). In some ways, Tamba demonstrates a unique and profound agency in navigating therapeutic worlds and notions of causality—amidst the otherwise overdetermining paradigms of global health funding and practices described in the rest of this dissertation, and which lead many nurses into a kind of quiet and accepting nihilism. But my point in shedding an "empirical lantern" (Biehl and Petryna 2013) on this cluster of concrete buildings tucked into the elephant grass on the border with Guinea is to show how much more complicated things are than either technocratic, or even some ethnographic, imaginaries of clinics as impersonal nodes for the delivery of a uniform corpus of medical care afford.

While not every nurse is as ambitious and creative in establishing himself as a renowned clinician, every single clinic in Sierra Leone is a nexus of models of diagnosis and treatment, individual clinicians' idiosyncrasies and social dynamics. These structurally decentralized, unsupervised and pitifully under-resourced facilities set the stage for and at times prompt clinicians' strategies of therapeutic *bricolage* with a range of effects. The delivered is often dangerous, and even deadly, even if it is consistently sought-out—and this is hard to wrap one's head around.

The Nurse and the Aide

Tamba's medical training began in the military during the Sierra Leone Civil War. He was trained as a State Enrolled Community Health Nurse (SECHN), a mid-level practitioner originally envisioned to staff intermediate sized primary health posts and to work under physicians and Community Health Officers. Though the SECHN course is three years long, Tamba emphasized often that the bulk of his training took place when a military doctor took a liking to him and brought him on rounds at the hospital in which he was posted. He loved working in these elite cadres of the Sierra Leone healthcare system, and the discipline and training involved. What Tamba gleaned most from his years in the military was a vision for structure, hierarchy, deference and discipline, a vision that he now tried to replicate within Kissibanga clinic. As is the case in all clinics in Sierra Leone, there were a network of auxiliary lay-staff who "volunteered" at the clinic: TBAs, the vaccinators, community healthworkers and "porters," who received some small funds from Tamba's till, or unpredictable stipends from transient government or NGO programs. Kissibanga clinic had also been assigned a salaried Maternal and Child Health-Aide (MCH-Aide) to assist Tamba with antenatal care and deliveries. In his effort to organize and "put things in place," he had developed fraught relations with all of them.

Tamba particularly hated nurse-aides, and told me proudly that in all of Kono district he was the "MCH-Aides' Enemy Number 1." This was why he was so fixated on letting the community know that Mabinty, the MCH-Aide assigned to Kissibanga, was involved in "transborder drug smuggling," "sexual promiscuity," and was "barely literate," and "can't be trusted." He had lodged multiple complaints about Mabinty with the local authorities and the

District Health Management Team. He accused her of breaking into his storehouse, locking clinic rooms and hiding the key, and "conniving with patients sexually." Tamba had shown many notes he had sent to the District Health Management team to try to get Mabinty fired, or even incarcerated.

Tamba explained to me one evening that his hatred of MCH-Aide extended back to his own childhood, when a nurse-aide botched his mother's delivery of his sister. Tamba did not speak much of his sister or what he meant by this accusation, but that night he dropped off in my quarters about a dozen notebooks in which he had written his "biography." When I flipped through his autobiography—written in strikingly beautiful prose— I read that Tamba's sister had had a mental problem for her whole life, due, he believed, to the nurse-aide's botched delivery.

Tamba's recollections of these conflicts always concluded with a vindication of his own intellectual, clinical and moral supremacy. But these tensions, which Tamba's favorite TBA said were "ruining the clinic," clearly began before my time. Tamba oscillated between being personally insulting towards Mabinty, telling me about the life-long consequences of his mother's botched-delivery, and speaking abstractly about the absurdity of such a low-trained nurse having a purview over primary care for an entire community. In these latter moments, I had the feeling that in addition to whatever personal qualms he had with Mabinty, Tamba's vitriol was a response to the endemic disjunctures between what was idealized and written in health policy plans and what was practiced in Sierra Leone's healthcare system: the unachievable staffing procedures, the imaginary communication systems, the clinical protocols that call for drugs that are never available, the plans left "in black and white" as that doctor had put it at the WHO workshop on hepatitis B prophylaxis. Professionalization and managerial acumen were *supposed* to solve the problems of delinquent healthworkers and poor quality of care—and yet,

none of Tamba's superiors seemed to take that maxim of "global health delivery" seriously. They rejected it, not as an articulated ideology, but in ways that appeared, to Tamba, unacceptably, nihilistic.

For instance, the Sister-In-Charge of nurses for the whole District had recently visited Kissibanga to intervene in the conflict between Tamba and Mabinty. Recognizing the futility of any effort at reconciliation, she resolved that Tamba should only see adult patients and should let Mabinty handle the children and pregnant women, even though Mabinty was only qualified as an "aide." While this was evidently the Sister-In-Charge's effort to pacify an overwhelmingly distracting feud in one of the District's most remote clinics, her solution also confirmed Tamba's sense that Sierra Leonean health authorities had abandoned pretense to matching qualifications to scopes-of-care. To simmer the tensions that were clearly impinging on patient care and could have potentially deadly consequences if the two clinicians continued to undermine each other's access to crucial medications, the Sister-In-Charge had made the determination that children and pregnant women in the region would now be seen only by a nurse who was technically only supposed to provide basic assistance to higher-level clinicians. Tamba insisted that this was bad news for critically ill pediatric patients who required a more senior clinicians' eye, but out of respect to the Sister-in-Charge, or perhaps just to stick it to her ("*let them see what will happen*!") he had generally abided by this new system.

Mabinty always seemed to me friendly, hard-working, if exhausted by the tensions. She was more prone to an exasperated shrug and going off and doing her own work than outright confrontation. Tamba's beef seemed, at times, so over the top I was inclined to discount it as purely personal, or perhaps something had occurred between them beforehand or out-of-sight. But this feud, and the accusations and interpersonal cruelty it entailed, was also a product of this

impossible situation: Tamba's resistance to the slippery relaxation of staffing standards that at once enabled the Sierra Leonean healthcare system to function *at all* (if no aides were to run clinics, nearly half might be entirely unstaffed), and his frustration that his efforts to structure and rigidly adhere to hierarchies of qualification, to take the art of clinic management seriously, were unmatched by superiors and colleagues. There was no vacuous discourse in Tamba's clinical space; nurse-aides should be aides, and that would make things *run better*. He recounted this idea again and again to the community, to patients and stakeholders: *in this clinic, we endeavor to adhere to the structures and hierarchies delineated by the Sierra Leonean healthcare system.*

But once, over lunch in Koidu, after listening to Tamba complain about Mabinty for nearly an hour I asked him, one last time: "What really is this all about? Is it about her lack of skills, her personality, the history of what the nurse-aide did to your sister?"

"It is a matter of resisting temptations, sexually," he said quickly.

"Your own temptations, towards Mabinty?" I had never thought about the optics of the two of the two of them sent out to this far-off village for months on end, the long nights alone in the clinic away from family. Perhaps this whole scenario, all the harassment, which had led to shifts in an entire village's access to pediatric and maternal care was Tamba's misogynistic way of dealing with his own temptations.

Tamba nodded once, emphatically, and then changed the topic of conversation. I was surprised by Tamba's admission—his expression of a certain type of a vulnerability, if you could call it that, and his fleeting recognition of Mabinty's own position of gendered vulnerability. No doubt, if I had asked her, after throwing up her hands and shaking her head, Mabinty would have affirmed this reading.

The Volunteers

As the tensions between Tamba and Mabinty grew, Tamba began to rely on other auxiliary staff to go between the two of them and to monitor what Mabinty was doing. Tamba had even aggressively recruited the TBAs to work on his own "side," even though they were technically supposed to work with Mabinty and the pregnant patients.

When Tamba arrived in Kissibanga, he had made a duty roster and monthly cook schedule for the TBAs. He told me that he learned these techniques of rostering and shift-scheduling in the military, when civilian volunteers attached themselves as helpers during the war, securing protection and food for themselves and soldiers organized them into support staff. In a sense these were patron-client relationships, a central West African socio-political arrangement, but formalized through the strategies and logics of efficient management and administration. "'Volunteers' have just transferred to 'TBAs' [in my mind]," Tamba explained. I joked that he should run a clinic management workshop. He was skeptical people would agree. "I don't like to impose…I like to have people come up with their own ideas and compare the advantages and disadvantages."

Kissibanga clinic also had two male auxiliary staff attached to the facility, who always seemed around the clinic: the Porter (a term used to describe the jack-of-all-trades who helped keep up the clinic, fetch things from the pharmacy, ready medications and injections and retrieve paperwork) and the Vaccinator. The Porter was a squat, muscular man, who exhibited immense pride in helping Tamba turn the clinic into a Center of Excellence. The Vaccinator was tall and

lanky, with a goofy, unsteady voice. He wore tattered clothes that were far too large for him, and had one cloudy, blind eye.

I found the vaccinator charming, though Tamba found him extremely frustrating to work with and lazy. The Vaccinator was often drinking at the one junction about a mile from the clinic where men from Kissibanga hung out for palm wine after coming back from their farms in the evening. He often did not make much sense to me but would burst into laughter at his own jokes. He had an arsenal of old English expressions he deployed, often devoid of context that I could follow. After drinking a lot, he would stand up with a hop and, dancing and jumping around, would say: "Ehhhhhh, you know what they say?" Then, nodding his head forcefully with each word: "*You. Can't. Teach. An. Old. Dog. New. Tricks! Ehhh? That's why they say: You. Can't. Teach. An. Old. Dog. New. Tricks!"*

The man had a goofy exterior, but would convey, at times, all-knowing and critical observations. For instance, the Vaccinator hinted that there might be some serious finances flowing through the clinic—not just the fees I had seen Tamba charging patients, but maybe pharmaceutical peddling as well. Tamba had written me long texts and letters explaining his efforts to catch Mabinty in the act of re-selling government supplied drugs to traders from Guinea, but the Vaccinator left hints that Tamba might be doing this himself. He would not go into specifics when I asked, merely repeating the famous *Krio* expression used to describe the inevitability of corruption in government and positions of public authority: "A cow will eat where it's tied." Something about the Vaccinator was threatening to Tamba and his grip on the clinic. When the two were together, it almost seemed like Tamba was scrambling to maintain authority that was unheeded by the shabby, inarticulate but forever unphased Vaccinator; as if the Vaccinator knew he was all bluster.

*

The primary anxieties that colored Tamba's life in Kissibanga pertained to witchcraft. I once asked Tamba if he had had any defining experiences that made him so attuned to the black magic activity he constantly referenced. As a young boy, he said, he had been walking one night on a journey with his dog, and noticed above the elephant grass a light that looked like a motorbike. He walked along, but it stayed near him, at the same distance. Tamba and his dog tried running away, but the light followed behind, gradually blinding him. He remained blind the next morning, and the next week so that he "couldn't function at school," which was devastating for the son of a pharmacist who wished to receive medical training himself.

A few weeks later, still blinded, a famous herbalist who had "even treated politicians in Freetown" arrived at his house without any prompting. The herbalist instantly recognized the problem as witchcraft performed by a jealous relative of Tamba's brother. Tamba's family confronted the relative, he confessed, and the herbalist cured Tamba. Before the medicine man left, Tamba said, "he told me I was very lucky." The witch attack could have been much worse, but the dog protected Tamba from the approaching curse—that's why it always followed behind, and never approached. Dogs can see and scare away evil spirits, "and that is why I am forever loyal to them." He kept dogs at his clinic, well-fed and groomed, and he talked to them, petted them, observed them, mapping out the pack's social structure, and treating them as companions during the long nights doing paperwork.

Tamba knew that Kissibanga was an absolute center for witchcraft and sorcery practices. David also told me that Kissibanga was known to be full of witches. It seemed like every time

we traveled to a remote village David or someone else from Koidu would say that *this place* was known to be *particularly* full of witches. Such attribution seemed to affirm or emphasize just how rural and different this place was from Koidu, or even larger Chiefdom headquarter towns. But in Kissibanga, David said, things really did feel especially tense. He once explained how this feeling became an embodied practice of suspicion: "Yesterday, as I walked through town, I was sucking on a chicken bone from lunch." He passed by two old men, and instinctively, as if a reflex, threw it away so they wouldn't see that he was eating meat. David's description aligned with the classic functionalist interpretation of the institution of witchcraft: the ubiquitous fear of witchcraft, even if nobody admitted to performing it, served as a "levelling force" in contexts of precarious material arrangements (Mair 1969). Perhaps, David and Tamba insisting that Kissibanga was *particularly* full of witches signified that it was *particularly* poor. In a place where people may only eat meat a few times a year, David's being spotted casually with a chicken bone could morph into something else much more dangerous: world-upending jealousy.

The constant references among the clinic staff to threats of witchcraft in Kissibanga indexed just how acutely aware everyone was of the disparities in class, cosmopolitan identity, education, skill-set and employment that the clinic had brought to the village. Tamba's authority was in part premised on these stratifications in the social order of this place. On the one hand, Tamba saw these villagers as in desperate need of his services and the messages he could impart on the importance of attending the clinic. But his anxieties about witchcraft were also a kind of equalizer, an attribution of agency to the surrounding population that he was forced to heed. Medicine here was not a mere transferal of skills, education and pharmaceuticals from clinician to village. Tamba had to navigate a careful dance around these hierarchies, and at times deferred

to the swirling sense of threat emanating from villagers attuned to, and ready to seek retribution for, conspicuous consumption and inequities in life-chances.

"Make sure you don't become close friends with any child or little girl—it will be a problem for her!" Tamba once told me. "No sooner will she be attacked by witchcraft, at night!"

The Witch

The Vaccinator was an oddball, but I did not expect David to tell me that everyone thought he was also a witch. "The way he behaves….suggests he does something different at night!" David said, bursting into laughter. He seemed to say it more in jest, like—*I'm sure this is what everyone else thinks*. But Tamba overheard and agreed. He had seen me spending with the vaccinator in the evenings and was clearly concerned about my developing a relationship with the man. Tamba explained that there was some "fearful fetishization, hence [the man's] eye." The Vaccinator had told me that his cloudy and blind eye resulted from his being gouged by a stick while walking through the forest. But out of earshot, Tamba told me (in his typical syntactically-inverted but affectively-potent way of storytelling) that the Vaccinator had "slapped an elder somebody. Reason was provided in retaliating."

David also said that the fact that the Vaccinator had been around the clinic for so long—the whole arrangement, his being stuck in this patron-client relationship with the in-charge nurse for decades—was odd. The Vaccinator reminded us frequently that he had been in Kissibanga when an NGO first came to build the clinic after the civil war, some 20 years ago, and that many nurses' regimes had come and gone in the intervening time. Other people would have moved on, David implied, migrated in and out of the community or set up a large farm, not stuck around

this building in a backwater village for two decades in a way that suggested that he was, as David put it, into the "whole 'system' in a bizarre way." David turned to me with a big smile. "It's like he's… *the protector of the place*," and made a bunch of flapping movements like a bat.

It seemed that Tamba and David were circling around something else that I couldn't quite follow. David kept using coded words ("protector of the place") and bursting into laughter, and Tamba understood whatever he was alluding to. The Vaccinator himself spoke frequently of the witchcraft, human sacrifices and illnesses caused by sorcery in the community, and David said that this also made him suspicious of the man's activities and associations. As anthropologist Samuel Anderson writes, "witchcraft is as mysterious in Sierra Leone as anywhere, reflecting the difficulty of classifying invisible evil, as well as incrimination risked from knowing too much about it" (Anderson 2019). Adept Sierra Leoneans speak of witchcraft through adumbrated language, asides, muttered accusations, abstract references to, for instance, a person possessing "something" that might serve as a fetish object or weapon. But to speak of witchcraft directly is itself a risk, requiring a certain type of verbal deftness so not to seem too familiar with the occult world; witchcraft is something one is "caught" in (Favret-Saada 1981), not something to describe with too much detail.

While I had become attuned to the tenor of these more elliptical conversations, I often had the sense that I was missing important references and wished someone would just explain outright what exactly had inspired the suspicion. Though I could not pick up on the subtleties of the Vaccinator's rhetoric vis-à-vis witchcraft accusations, given his off-beat humor, his jester-like status in the village, I could imagine that he might be less effective at reading others' cues of suspicion, or knowing when to hold off on speaking of the threat entirely. The swirl of rumors and insinuations about this man began to seem, in part, David and Tamba's way and language of

encountering the man's idiosyncrasies, even his irritating presences. And when I probed further, Tamba's accusations that the Vaccinator might be a witch morphed, yet again, into questions of professional recognition, structure and hierarchy. "The District Health Management Team is no longer *recognizing* Vaccinators anyway," he said, as if it legitimated his point and accusations. Another time, he said that the Vaccinator's family had just "dumped him [here] because they had no use for him." Now Tamba was stuck with taking care of the man, despite there being no clear role for him at the clinic. "It was like a dump." Excluded, untethered to a family or land, the Vaccinator had been caught between regimes of recognition, accusation and clinical professionalization. But perhaps Tamba was just groveling for ways to undermine the one character in the clinic and village who seemed unimpressed by Tamba's prowess and expertise.

The tensions erupted at times in public and embarrassing conflict. One day, in front of a dozen straight-faced patients waiting in line to have their names written down, Tamba and the Vaccinator had a huge yelling fight. The Vaccinator had taken an empty calamine lotion bottle to fill with palm wine in town. Someone reported that to Tamba, evidently knowing how much it would incense him. Tamba sent someone to chase the Vaccinator down in town. The Vaccinator came stumbling back, first denying taking anything at all, and then erupted into a yelling fit. The Vaccinator, in an almost self-mocking tone, says: "Why can't a Vaccinator take a *funny funny cup*?" again and again. After all that he does, after all the work he does, all this yelling for a *funny funny cup!* "So you see?!"

Tamba grabbed the Vaccinator by his loose polo shirt, snatched the cup and threw it in the trash. He looked at me: "This is about maintaining discipline," he said, "you give an inch they take a mile!" He learned this in the military, he said—discipline extends from a cup, you let

him have this he'll steal drugs next. Tamba turned back to the Vaccinator and said: "You know what is *discipline?"*

The Vaccinator burst into laughter: "You know what is *Free Healthcare*? Ha! Mr. Tamba! Tell me, you know what is *Free Healthcare?!*" He was alluding to the Sierra Leone Free Healthcare Initiative, disregarded by Tamba who charged fees for all of his services. (Not that the Vaccinator had expressed any qualms earlier when Tamba distributed some Leones to him from the pot each night.) This donor-driven policy, one that was never really fulfilled, had become an ironic trope, fodder for disgruntled patients or staff to lob at clinicians who had to cobble drug supplies on their own. I had seen other fights over the years when local community leaders or patients, angry at the clinic's nurse for unrelated or personal, would express their bitterness as accusations of violating this impossible-to-enact law.

I was struck by the Vaccinator's undercutting and refined quip. I wondered if it also conveyed the man's discomfort with the empire Tamba was building, the subtle ways that it might start to exclude the local power-players who had managed the clinic long before Tamba's posting. Maybe the Vaccinator was implying that he was, drunken and angry, the *real* Protector of the Place.

This back and forth continued for some time, before the Vaccinator wandered off yelling down the street. He would be suspended for some time, Tamba told me. The Vaccinator typically handled the store-room, cleaned the clinic, and generally seemed busy, but Tamba told me that he was no longer even allowed to give vaccines. The community had "neglected [him] because of a series of abscesses," Tamba said, that were caused by improper injection of tetanus toxoid.

Later, when I was in town interviewing others, the Vaccinator came by and sat down and started playing with a little child, bouncing her up and down and saying: “Free Healthcare. We have, have *Free Healthcare.*”

He met me again in the evening as I sat on the ledge of the lodge. It was remarkable how much time the Vaccinator spent at the clinic, and even in this dejected state, it seemed he had nowhere else to be. He passed me some palm wine in an old plastic *pastisse* bottle, and said he was “*disgrunt*” many times. Right then, he seemed so small, dependent on the precarious position as a peon in the clinic, beholden to Tamba and ambitions of personal grandeur—not a protector of the place. And then, when I wasn’t really paying attention, he added: “I’m disabled, I am disability here because of my eye.”

Confronting Dependency

Tamba’s father had owned a pharmacy in Kailahun District, out of which he had supported a large compound and several wives. Tamba respected his father’s commitment to his patients, his reputation and clinical acumen, but seemed most inspired by the way his father had built a sort of empire out of his clinical practice. He had linked agricultural projects and community groups to his pharmacy, and, even though his father was not formally trained as a pharmacist, had arranged for other clinicians to pass through the village to treat patients. “My father *started* ‘Free Healthcare’ in Sierra Leone,” Tamba said, again somewhat ironically referencing the 2010 initiative. He provided rice and social support for dozens of patients, which Tamba aspired to do as well but was wary of the personal financial costs. And his father could cover the costs of treatment for the indigent with the profits from coffee and cacao from his plantation. The man

practiced decades ago, long before the neoliberal agendas of cost-effectiveness and financial sustainability had permeated all aspects of global health funding and practice. But in Tamba's recollection, his father's clinical, financial and managerial intuition had anticipated the models that now, under conditions of austerity, held the most promise.

I suspected that Tamba was embellishing this lineage of benevolent and renowned clinicians, and that more complex relations may have been at play in his childhood village in Kailahun. Tamba's was adamant that there were risks to making his services in Kissibanga appear *too* motivated by his own humanitarian spirit. When one gives free medical care to an impoverished patient, Tamba explained to me, when they see you as a potential benefactor and begin to reveal the extent of the social and economic problems they face, then one can quickly become overwhelmed, both financially and emotionally. This is a familiar experience for any visitor through Sierra Leone as well, one that I agonize over every time I'm in Kono. My relationships with friends and interlocutors almost always often entail periodic requests for small sums of money to solve critical, and at times life-or-death, issues—a bag of rice for a hungry family, school fees for a child driven from the classroom in front of her friends, or medicines, surgery or a blood transfusion for critically ill patients. These requests snowball; there is no ethical stance nor politics to legitimate extricating myself from the real precarity of others' lives, a precarity that, at each moment, seems eminently solvable with small amounts of cash. It all becomes heart wrenching, a vortex, inescapable. "When do we draw the line between what we feel we must give 'to make a difference' or redress a historical wrong?" Michael Jackson writes of this dilemma,*"* and what do we owe ourselves, what we must keep if we are to live?" (86). With the impossible disparities in wealth between even an American graduate student and most people in Kono, even articulating this dilemma seems obscene.

I could only imagine how intense this impasse must be for Tamba, immersed for years in a village in which, just by virtue of his tenuous and small government salary, he represented to the local farmers and miners such extraordinary access to wealth and resources. The answer offered by the neoliberal development juggernaut was an economic and behavioralist one: that one *cannot* give people too much for free or they will come to expect it, that ultimately it is in patients' and the country's interest to eschew a (supposedly impractical) notion of medicines and food as public goods: *dependency,* between patients and clinics, or clinics and donors, is to be avoided at all costs. Patients must be made into clients, clinic-managers into entrepreneurs—and this was what, to a certain extent, Tamba's father had managed to do.

But Tamba had also devised a set of concrete criteria to prevent himself from being caught in overwhelming webs of obligation, and to blunt his emotional ties to his patients. For instance, he did not allow patients to name their kids after him, a common way that bonds of attachment and affiliation are made concrete in Sierra Leone. Tamba explained, "I don't give namesakes, because when you get a namesake you have to give respect and moral"—by this, he implied, material— "support. When my father used to have rice, all his namesakes used to come asking for rice." I wondered whether his frequent asides about the local peoples' improper behavior and their bringing health problems on themselves also served to secure some emotional distance for Tamba.

This kind of affective ethos towards the inescapable and never-ending nature of clinical and material need in Kono is different from the dependency arguments of some of the global health NGO managers I had met (that there is *moral* (in addition to economic) hazard in creating *dependent* postcolonial patient-subjects that may ripple out into other domains of life.) Tamba, here, was wary of empathizing or caring too much—that doing so would make him simply not

able to continue to live. But in Kissibanga, where the neoliberal ideologies of financial sustainability, entrepreneurial clinical and patient subject-hood, and cost effectiveness had met their audience, these two concerns—the moral hazard and the affectively-overwhelming nature of dependency—were evoked together.

All of this was, in essence, the flipside of the argument that women in Kono do not seek prompt care for their children because too many of those children die anyway: that women in Kono must be taught to name their children earlier, to have *feelings* towards them, to *affect* (see, e.g. Pinto 2008) and thus to attend clinics (see chapter 3). The nurses on whom those women might depend, in turn, struggled *not* to feel; Tamba *denied* the affective—and, in Kono, always closely-linked, material— power of a name.

Through all this, Tamba seemed to convey different visions for who he wanted to be as a nurse. He certainly saw himself, and demanded respect as, an expert clinician. He also wanted to be well known, beloved and protected by the villagers around him, even while at times blaming them for their own conditions, and suspecting many of the villagers of sorcery and witchcraft. He acted as a humanitarian, selecting patients he deemed needy and worthy of food, sponsoring school fees and travel to Koidu for hospital referrals, and he worked to balance his desire to give everyone rice with the perils of having too many namesakes when the salary he received was so small.

But sometimes, he seemed to be living a fantasy borne of his days in the military. Every text message or voice note he sent me, for instance, was structured like a military transmission, with the time (in military format) preceding the message: signing off, “Tamba, Kissibanga Village CHC”. There was a kind of role-play here, like the ex-patriate volunteers I had worked alongside during the Ebola epidemic, as if Tamba were dispatching communiques from an

outpost on the frontiers of multiple forms: epidemics, clinical infrastructure, the occult. I wondered how he balanced his own unchecked desire for supremacy and clinical authority with a kind of vision for what his life and practice could be if it fit into a broader hierarchy, bureaucracy, collaborative structure— if the Sierra Leonean healthcare system, the NGOs and the donors were not all so structurally indifferent to what Tamba was building out in Kissibanga village.

The Nurse's Care

By 6AM or so, patients began arriving each day. Most of them came from Guinea, and many spoke no Krio nor French, just Kissi. The population in the region is highly-mobile and integrated, traveling frequently to and from mining sites, markets, hospitals and healers across Liberia, Sierra Leone and Guinea, but largely within a Kissi Triangle that transcends the three state's borders as a self-contained economic and cultural nexus. Many had not traveled to Freetown, Conakry nor Monrovia before.

When patients reached the front of the line and had their names and problems written down in Tamba's logbooks, Tamba would sit back, think, and explain the planned course of action while looking at the table, so quietly that the patients would often need to lean across the table. Then, suddenly, speaking with utter clarity and certainty, Tamba would announce an exorbitant fee. The amount was often far more than what a rural farmer would earn in a month— even up to $100. The Free Healthcare Initiative categories had no bearing in Kissibanga: pregnant women, children, adults all knew they would have to pay. Sometimes, the patients would look at their feet and their mouths would crack with a bit of a smile. The patient or couple

might then ask to excuse themselves, walk to a private area and discuss. Then, they would come back and sit down, and the man would pass over $5 or so. There was no protest, no negotiation, the transaction was done silently. Tamba would then write the amount received in a ledger and calculate the remaining balance.

Tamba's prescriptions were often more treatment-plans than services-requiring-immediate-fees; they involved coming back regularly for monitoring and ongoing administration of injections and tablets. Thus, the fees charged by Tamba seemed more akin to subscription service, a contract for an ongoing relationship of care, a relationship that we all tacitly knew would be impossible for many of the patients to sustain given that they had traveled great distances and had left their workplaces and farms to see Tamba. In fact, I saw no evidence that patients really ended up paying even close to the full amount demanded in that initial meeting. But Tamba did make enough money each day to distribute from a collective pot to the unsalaried auxiliary staff, to make some funds for his family staying in a village closer to Koidu, and to keep his parallel drug supplies coming since the government stocks were so unpredictable. With little supervision, and few drugs coming, it seemed that despite all the rhetoric from the Sierra Leonean Government and the British donors about the progressive "Free Healthcare Initiative" these market logics of neoliberal public health were, at a structural level, the unstated plan to keep Kissibanga "in business" all along.

In other clinics in the area, this scarcity, precluding the possibility of a practice premised on etiological certainty, defined, and constrained, every aspect of clinical care. Clinical encounters in these more lethargic and empty facilities had been reduced to two simple questions— "is there a cough" or "is there a fever" – as the only pieces of information that the nurse or nurse-aide used to decide whether to prescribe broad-spectrum antibiotics or

antimalarials (if those were even available). Tamba, however, always cobbled together a diagnostic process before formulating a plan, even if this involved using the medical technologies at hand in unusual ways. For instance: Tamba said that when rapid malaria tests were available, he watched the level of the result line. While the test was officially intended by its makers and marketers to be read as a binary "positive/negative," he used the color and level of the line to assess the level of anemia, and whether to give an extra injection of quinine before standard antimalarial treatments. One night at his clinic, when I had a slight fever, he pricked my finger for a rapid test and studied the viscosity of the bubble of blood on the surface of my skin; the less viscous, he said with certainty, often indicated an increased parasite load. (He deemed mine quite watery, but the rapid test was negative.)

Or another example: when a patient came complaining of abdominal pain, Tamba first pointed his infrared thermometer gun at the patient's forehead. He then pointed it at the patient's abdomen, to take what he called an "enteric temperature." I asked him, genuinely curious, about this diagnostic parameter. It made some mechanistic sense, but I explained that, according to my own understanding, that there was a difference between a "fever," which is a central physiological phenomenon arising from the temperature-control center of the brain, and inflammation in the intestines due to an infection which might indeed lead to warmth but would not necessarily be ascertainable at the skin, nor even calibrated at the same scale as the forehead (ie, the intestines or the abdominal skin might not be 98.7 degrees Fahrenheit). Tamba said something about "in thermal physics…." but then interrupted himself to explain that in fact he had seen enteric temperatures more than 40 degrees Celsius. "It's really as a check and balance, to conserve drugs and show mothers there's some criteria so they understand. We must limit the flow of drugs out or no way they'll last….so I say: 'Let's hang on.'" I was perplexed: Tamba

was on the one hand adamant about this diagnostic technique's utility to get a sense of the what was unfolding beneath his patients' skin, but then seemed to cast doubt, or at least uncertainty, about whether these pre-treatment procedures could actually guide clinical management, or whether they really just served as a performance to make the patients take this all seriously, and to understand that he was not just any old drug peddler.

Tamba's diagnostic techniques almost always involved similar acts of "reading in" to the few technologies and clinical exam findings he had at his disposal in unexpected ways: creative uses of the malaria tests and thermometers, but also holding bags of urine up to light to the note the color, or meticulously documenting the patients' subjective responses to powerful pharmaceuticals. "One should give space between administering Septrin (an antibiotic) and ibuprofen (an analgesic)—for liver function," he told me once. "But—if the patient belches after the septrin, it's ok. This is a sign of proper and prompt absorption and assimilation."

At first, I was perplexed and even shocked at the ways in which he treated various objects or byproducts of his clinical work as polysemic, encoding unusual meanings that could only be ascertained with (his own) expertise. But as he explained how his long-term experience as a clinician had opened up new meanings hidden in these medical technologies, I began to think of other situations I had encountered in Kono's hospitals and clinics in which clinicians, sometimes emphatically, insisted upon the multiplicity of meanings conveyed by objects of clinical care. Many clinicians in Sierra Leone—particularly higher-cadre physicians—were more inclined to stick to "the books." But Tamba's diagnostic process here, this hermeneutic of *reading-into* medical technologies as a form of expertise, was not unique nor unprecedented in Kono.

One European physician who had worked at the government hospital told me, for instance, that a Community Health Officer adamantly insisted—to colleagues and to patients—

that he had learned that the color or appearance he saw in the well of an unspecific typhoid test could be used to ascertain the proper a dosage of antibiotics, even if the strength he deemed appropriate was far greater than is typically indicated. Patients came frequently to the Ichende Clinic to seek a "scan" of the body, and nurses offered them the opportunity to peer beneath the skin though they had little training in the interpretation of ultrasound. Physicians complained to me that the x-ray machine donated by a US-NGO was used as a kind of exploratory test, even when patients did not report anything involving bones. As I spent time in the wards of the hospital, I could tell how much patients, in turn, appreciated these x-rays in the contexts of the hours and hours of waiting idly, unattended, during their hospital stays. The patients were accessing a critical object of care that had been unavailable to them for decades, and the fact that the hospital nurse had the authority (through the scribbles on a prescription sheet) to enable a few moments in front of the x-ray machine seemed to buttress patients' confidence in the care offered at the hospital. And I had heard many different laboratory technicians and nurses describe, like Tamba, the double-meanings encoded in rapid tests and blood; the knowledge of how to read the color, consistency, surface tension and thickness of the blood droplets borne of the many tedious hours running malaria tests in clinic labs. With clinical experience spanning decades, these healthworkers developed a "deeper" familiarity with the technology, tinkering with it, exploring its novel uses and signifiers, grappling with its opacities and uncovering what was underneath.

Expatriate and higher-cadre Sierra Leone clinicians alike often attributed these tinkerings to what they called the "poor" training of nurses in Sierra Leone. Clinical training programs (other than those leading to medical doctorates) involved very little basic science exposure, education in pharmacology, or understanding of the biochemical mechanisms underlying a rapid test, a drug or even an infection. On the other hand, a typical anthropological perspective might

be inclined to characterize these practices as a kind of scrappy and inductive local clinical know-how borne of years of experience treating malaria, intestinal infections and typhoid in this context. I was certainly inclined towards the latter until I underwent my own (incomplete) training in clinical infectious diseases. I knew of the anthropological concept of "local biologies"—that the body and the social are so inextricably entangled that biologies are fundamentally different in different places—and perhaps diagnostics actually operated differently as well (Lock 2017). But I had also studied the mechanisms of many of these diagnostic tests, and this led to an impasse: the subtleties of dyes in the wells of a Typhoid Widal Test (a 19th century test with a specificity of only 18%) have nothing to do with the necessary antibiotic dosage, for the test measures the agglutination of antibodies at increasingly diluted concentrations, not bacteria.

But these practices do fit into a broader landscapes and epistemology of material culture in Sierra Leone. Many anthropologists have written on the cultural order of secrecy and concealment that pervades politics and social life in the Mano River region. Mariane Ferme (2001) has explored how these "hermeneutics" of secrecy extend to material culture: the ways that one's skill as a hunter, historian or steward of cultural practices is exposed by one's ability to read "clues from surface signs" (26). Among the Mende people with whom Ferme worked, the "visible world (as it appears, for instance, in ritual, political, and domestic appropriations of public space) is activated by forces concealed beneath the surface of discourse, objects, and social relations" (2). This structure of thought vis-à-vis materiality is recapitulated in many domains of economic and social life. For instance, certain ordinary objects like bottles and mirrors may be read by renowned healers as *actually* objects of enchantment and magical intervention (see next chapter). Secret codes and inscriptions written on the insides of sodality

masks doubly veil the esoteric knowledge and status of the wearers. And, as Ferme points out, the primacy of the "underneath of things" is also critical in Kono's most important economy: the capacity to look beneath the ground to discern "a diamond from among many worthless stones with similar dull surfaces" which may be a conduit to extraordinary wealth. "The skill to see beyond the visible phenomenon and to interpret deeper meanings is, then, a culturally valued and highly contested activity," Ferme writes, "Because on it are predicated all social and political actions and different forms of wealth" (4).

Tamba's tinkerings, in other words, were not just "bad medicine" or "misunderstanding," though their "effectiveness"—whatever that meant—was still undefined. They also emerged from a local expert knowledge, one not necessarily confined to the epistemic structures of clinical medicine. Tamba had learned to read-in to the malaria tests, urine bags, and blood samples—to see things that ordinary people, even ordinary clinicians, could not see. He did not take the material objects within his clinic for granted. Memorizing the "proper" drugs to give for each suspected pathogen, or passively reading a malaria rapid test, could only go so far. With time, attention and the commitment to tedious study, other valences, meanings and signifiers could inevitably be revealed and known—and this, in Kono, is a critical marker of expertise.

Ambitious Care, Uncomfortable Collaborations

Tamba liked to tell me stories of his most famous patients. Most recently, there was a big scandal in the Chiefdom when a hunter who had an illegal gun left his firearm in the grass by the road to pick up the next morning. Someone else found it, lifted it up and shot himself in the hip. Tamba told me he had to do "intensive care" of round-the-clock IV fluids and bandaging at a high price, which had led to a drawn-out dispute with the Chiefs about who would cover the

costs. Tamba showed me his receipt books that served as a sort of time-table, calculating the amount owed based off of his hours in the clinic and his "intensive-care-unit hourly rate." I wasn't sure where that rate had come from, nor if he had ever referenced it beforehand, but he was a meticulous record-keeper, as if the receipts and the timetables substantiated the care he provided. Ultimately, he said, the heavy-protein diet he prescribed upon discharge was most critical reason for the man's remarkable recovery.

Another one of his complex patients: a man who was constantly vomiting but refused Tamba's putting in an IV. Tamba said, as an alternative, he gave the man a ciprofloxacin infusion rectally using a syringe, and then pumped him full of vitamin B12. "He became a famous case! Tamba explained. "He who was not eating is now eating plenty, so troublesome!"

"Did you invent that or learn it?" I asked of the ciprofloxacin enema.

"I just use common logic— in emergency you have to go all out to save a life. And afterwards amend anything."

Another day, an old man came to the clinic with an enormously bulging abdomen. Tamba went through his registers to review the history so he could tell me the story. The man first presented 3rd April with, Tamba read aloud, "ascites, hydrocele and semblance of oncho, lizard-skin like presentation." He read these out as if they were a triad of symptoms, but I was attuned to each signifying a distinct process: fluid in the abdomen due to backed-up pressure in the portal vein supplying the liver; a relatively benign swelling of the testicle; and a dermatological condition. Tamba waited to see if there would be any reaction to ivermectin (a medication for parasitic worms) he prescribed, then tried to get the history of this abdominal swelling. "He was saying that it began five months ago, but the hydrocele had been with him for the past ten years."

To Tamba, the two were connected, and he puzzled over this case. “So I went and consulted with a Community Health Officer (CHO) in Koidu.”

Tamba referred to this confidant, named Dauda, frequently. He said he had long been in conversation with man about doing outreach surgeries for hernia, appendix operations, and other elective surgeries in Kissibanga. Dauda “bought the idea” but asked for a formal invitation, “at Chiefdom level.” After that he would visit the clinic, and the District Health Management Team would assess the standards for Infection Prevention and Control for the clinic, and a proposal would be put in place; the community would be sensitized, those that could not afford money for their surgeries could pay in goats or other livestock. “But when I came and told the Section Chief— to him I was a threat. So he didn’t buy the idea and couldn’t invite the chiefs to give the idea across.”

In the absence of a formally-trained surgeon and with patients desperately in need of care and unable to reach the capital, Tamba had begun performing minor surgeries on patients. On this man, he had tapped the ascites by puncturing his abdomen with a catheter to drain the fluid. Tamba had then adjusted the dosage of a powerful diuretic based on what he ascertained was the man’s blood pressure. “On 25th May acute, there was acute retention oliguria, clear prostate enlargement—I inserted a catheter [into his bladder] and the output was 1600mL,” Tamba read. Later that day, when Tamba was monitoring the color and consistency of the urine, Tamba noted a collection of 160mL, but it was “very slimy, like a mucous.” Four days later, he studied the urine was purulent, cloudy, like “Nescafé and milk tea.”

Tamba commenced a series of powerful antibiotics and continued monitoring the urine. He peered into the urine to figure out what was going on in the body, and what effects the powerful pharmakon being pumped in the man’s veins had had. “Twelve hours later, the man’s

urine had turned brown." One week after that, after he started another antibiotic, Tamba told me proudly that the man was "down to only 500mL of urine and it was clear!"

As Tamba told me this clinical history, the cause, effects, it was dizzying to figure out what he considered etiology and what was treatment. Highly technical in his assessments, Tamba drew on a rich clinical vocabulary (ascites, oliguria, purulent). But tapping ascites seemed like a rather invasive procedure to do out in Kissibanga. I asked him where he had learned to do it, expecting that he would say from one of his surgical medical textbooks from the early 1990s, that I had seen him use before to guide invasive procedures. When he was in in the military, Tamba said, the doctors supervising his "post-basic training" knew that Tamba should be involved in all procedures—with his work ethic, they knew that if they left him out there would be problems.

I asked if, officially, nurses are allowed to tap ascites. "Well, no. But really based on your experience, *you are responsible for any problem*." The question of liability, here, was not about whether clinicians would be held responsible for the consequences *of the procedure* (for how would word ever get back to his superiors if he were to botch something? Patients die so frequently in hospitals, there would be no way to disentangle what was a product of malpractice versus neglect versus simply absence of essential medicines.) But Tamba *would* be responsible, via rumor and a damaged reputation, if he were seen *not* to do anything for patients whose conditions exceeded his formal training. Tamba seemed to be saying that in Kissibanga, making visual his consistent effort for patients—via elaborate and spectacular procedures like tapping the fluid from abdomens, and in arranging drawn out negotiations to make his clinic a surgical center—was a form of care itself.

Another time, Tamba found me while I was writing notes in my quarters. A woman had come to the clinic with an "enlarged liver, amenorrhea, some type of ascites." He started to explain the history. He had begun providing her metronidazole, an antibiotic, for "unexplained abdominal distension and amenorrhea; [her periods were] coming as 'spot-black.'" Now he needed to figure out, by "hanging heads together", whether the condition was "pre-menstrual, or liver, or what."

I had already begun to feel uneasy with this positionality as a collaborator rather than observer, and here he had explicitly named me as a kind of co-diagnostician. I threw up hands and said, "this one is really left to you," but he beckoned me into the exam room. Tamba had the woman, probably about 40 years old, lie on a table. When her abdomen tightened, I could see a speckled and bumpy liver all the way through the taut and thin skin. It looked hard, like a rock, clearly cirrhotic or covered in tumors. The woman already had some fluid building up in her abdomen, from blood backing up, unable to pass through the dense and tough liver tissue. Tamba continued to poke and prod her, to find a diagnosis that could connect together the liver issue, the abdominal pain, the "black, spotty" menstrual periods.

"One of the things I normally get frustrated by with my nurse-aide is the recycling of syringes and injectable materials," he said. He hadn't mentioned Hepatitis B as the most likely diagnosis for the woman, given the over 15% prevalence in the area (Bangura et al. 2021; Lakoh et al. 2021), but I wondered if he was implicitly suggesting that she was infected in the clinic. "If you are making money, you really must purchase new materials."

*

Many of the patients reported symptoms of sexually transmitted infections. I had no doubt that these diseases were rampant; there was a great deal of mining in the area, so men came in and out of the villages all the time, and I could not even fathom where one would find a condom. I had heard a lot of jokes around the clinic about how there is so little to do in Kissibanga at night that if one went into any house after dark people would be having sex. "That's why there are so many kids here!" the male community healthworkers and auxiliary staff often told me, beaming, when they were about to disappear in the evening to go visit a girlfriend.

Tamba diagnosed what he called "chlamydia/gonorrhea complex" or "syphilis" in nearly every patient, often with a scolding sense of humor. He did not recommend protection to anyone—it's preposterous to suggest a condom, he said, because nobody would have any interest. Tamba also opted not to counsel or test for HIV, despite all the workshops and programs NGOs and the Ministry of Health implemented in the region. Tamba said he did not want anything to do with delivering an HIV diagnosis. I had heard a story from a few people, including Tamba, about a nurse stationed at Penjuma (the village he was assigned to before Kissibanga). She had conducted an HIV test on a woman who she suspected of having the virus. The test had been positive, and she had secretly informed the patient in order to enroll her in a free ARV program. The woman refused to believe the result and went back to her village and told her husband, who was furious. He confronted the nurse and threatened her, telling her that she had lied about the test result. One month later, the nurse was dead, and everyone in the community knew that the couple had arranged for the nurse to be killed by witch.

In addition to the fear of retribution for delivering an HIV diagnosis, Tamba told me (echoing anthropologist Adia Benton) that as an "exceptional" disease (Benton 2015), with so much donor money tagged to HIV care, he would not partake in any regime of HIV diagnosis or

treatment unless he received a significant salary top-up for that work. There was a sense of justice in this proclamation—the money was there, the NGOs like Alliance for Health Justice were "chopping" it—but also a notion that deserved a "hazard pay" if he were to give people HIV diagnoses in such a tense and sorcery-riddled community.

Chlamydia, gonorrhea, syphilis—these were less hot-button things to diagnose, and dozens of patients came each week smiling sheepishly as they explained in front of all the other patients waiting in line about their burning genitals and trouble urinating. Often, Tamba would dose them up with different varieties of injectable and oral antibiotics and sent them on their way; other times moral valuations became enfolded into the clinical plan.

Once, for instance, a young man came from Guinea to see Tamba for urinary discharge, and, he said, a small fever. Tamba asked him to bring wife for treatment because, he said, the condition was "getting to subacute" stage. Tamba said this phrase a lot—it indicated his determination that a patient had been in such a generally poor state of health that the specific condition morphed into a general state-of-being. In this case, he prescribed a single injection of antibiotic, but refused to give it yet as the young man needed to show he would "appreciate it" by bringing his wife in for a physical exam. This almost sounded like the discredited but still widely-circulated argument (among NGOs) that Sierra Leonean clinics ought to charge small amounts to be seen, as patients will better "appreciate" and comply treatment regimes if they have had to "sacrifice" a bit of money (see e.g. Ahonkhai et al. 2020; World Health Organization 2005).

Another time, a young woman with a sore throat came from Guinea with her partner. The ones who travel from Guinea often came as a pair, and it offered an opportunity for the other one to bring up the ailments he had as well, to take advantage of the opportunity to be seen by this

well-known nurse. In this case, after an aggressive interview in Kissi, Tamba turned to me. “It’s gonorrhea of the pharynx,” he says. “There is a purulent discharge and from history I learned she was in the habit of sucking the penis of her boyfriend.” This seemed plausible, but in a place in which the specificity of sexual acts are not frequently described, and after the aggressive tenor of the interview—and all of the other causes of sore-throats in Kono— it seemed Tamba may have pieced together a story with the goal of precisely pinpointing the self-destructive behavior that had led to the woman’s condition.

Several patients came to request fertility treatment, or treatment for erectile dysfunction. He told me that he only offered these fertility treatments when both members of the couple are present. He seemed to have a stipulation or “criteria” like this for nearly every treatment, and I could not always follow his reasoning, other than that he wanted the treatment to be “appreciated.” He was serious about wielding his care to enforce the criteria; there was one family he was having a conflict with and said: “If they don’t agree I will tell them they can no longer get medicine here.”

I asked Tamba if he prescribed pharmaceutical treatments for his infertility patients. He nodded, and listed off several endocrinological drugs used in the United States for fertility treatment. I was impressed he had even heard of them, as I certainly had never seen them in pharmacies in the country, and I wondered whether he actually managed to acquire them and distribute them to these couples desperate for children.

One morning, as I rose from my quarters, I saw him talking sternly to a wide-eyed young man and woman in their early 20s. He had one of his many anatomy and physiology books out, speaking in fast Kissi while pointing at a diagram of the female sexual organs. He looked at me and told me to take a seat—this is the beginning of their treatment, he said. He was explaining

the importance of the male providing adequate sexual pleasure to the female partner by focusing on the proper anatomical areas for fertility.

Experimental Medicine

Tamba's treatment plans were well-articulated and internally coherent. But often, his prescriptions were not even of the class of pharmaceutical designated for the diagnosis he had listed off. Caustic soda and diazepam for a "severe inguinal infection"—two chemicals that do not act on bacteria. Antibiotics that are only made active by enzymes in anaerobic bacteria prescribed for ordinary pneumonia, a condition caused by bacteria in oxygen-rich lung tissue. Other drugs prescribed for chlamydia that would not be able enter that bacteria's cell-wall. Blood pressure modulating drugs only indicated for pregnant women prescribed for men with severe heart failure. Powerful antibiotics injected casually for aches and pains. Psychiatric sedatives distributed to women to give their children to go to sleep.

Tamba's medicine—the medicine that patients sought in Kissibanga— *was* these pharmaceuticals. While scholars of global health have critiqued the broader "pharmaceuticalization" of global public health, that is, the ways that transnational health actors have increasingly aligned agendas and funding-streams around a definition of health as access to pharmaceuticals (Biehl 2007; Greene 2010), a set of commodities, in Sierra Leone today, a notion that medical care *is* pharmaceuticals is deeply entrenched—and defines the standards to which ordinary people and patients hold clinics and healthworkers. *"Pepe doktas"* [pepper doctors] peddle an unregulated trade of antibiotics, anti-malarials and powerful analgesics

throughout the district, offering injections for nearly all conditions. Hawkers on the street push wheelbarrows full of vitamins, antibiotics and other dubious supplements from China, India and Nigeria. The Sierra Leonean healthcare system may generally be in disarray and often the clinics themselves lack government-supplied medicines. But rural Sierra Leoneans' bodies are not beyond the reach of the modern pharmakon.

There often seemed little order to the prescriptions that *pepe doktas* offered in Koidu or larger villages. Patients even took it upon themselves to select the antibiotics, pain medications or malaria treatments they thought appropriate for their conditions at pharmacy stalls. At Kissibanga clinic, on the other hand, Tamba's treatments were unambiguous and always adhered-to, but he often framed his pharmaceutical prescriptions as if they were simultaneously therapies and empirical investigations. For instance: one afternoon, a child, probably two or three years old, came in with a skin infection extending under each arm and over her neck, back and trunk. She had scratched so much that the infected areas of her skin were nearly completely white and peeling. There were no antifungals to treat what is most likely a ringworm infection, so Tamba prescribed on the patient log, and then proceeded to crush, two vaginal inserts for yeast infections in a piece of notepaper. He then poured the powder in a hand sanitizer squeeze-bottle that had been sent to the clinic to aid in health worker infection control and shook the mixture into a gelatinous suspension. This is meant "as a trial" antifungal lotion, he told me, "for research purposes— I just want to know whether it will work."

Tamba was not generating knowledge for knowledge's sake, however; the experiments were driven by the unstable drug supplies, the fact that he *had* to improvise with what was at hand. Clinical pragmatism and a kind of unchecked experimentation became blurred: vaginal inserts crushed into hand sanitizer gel as an anti-fungal treatment when other options were

lacking; ciprofloxacin enemas when a patient would not tolerate other antibiotics; "intensive-care-unit" services in a clinic without power. Watching Tamba practice these medicines-cum-experiments, I thought frequently of the American physicians who would come to volunteer with NGOs in Kono, and who often channeled their horror at the decrepit state of the Government Hospital and the patients dying from treatable conditions inside into a kind of unchecked clinical ambition. One internal medicine physician who had heard that psychiatric patients were sometimes chained in the community began dosing psychiatric patients with powerful psychotropics with potentially life-long side effects. I had watched as emergency medicine doctors performed minor surgeries on women dying of abscesses and horrific infected wounds in the acrid and public general medicine wards, while patients babbled away under ketamine-induced psychosis.

Clinical creativities abound in Kono, driven by all sorts of actors, logics, rationalities, interests and epistemologies, leading to a broader order of something like what Adriana Petryna calls *experimentality* in public health systems and practice in resource-poor settings. In these contexts, ethical oversight is less stringent but the resource constraints and clinical needs are used to justify regimes of treatment that generate valuable experimental evidence (often for pharmaceutical companies, but in this case for American academic physicians' careers, or Tamba's clinical authority) as a "win-win" enterprise.[54]

[54] There is in fact a much longer history of African frontier health systems serving as sites of experimentation, where the lines between delivery of clinical care and knowledge-generation on pharmaceuticals, public health models and pathophysiologies have been blurred (Geissler 2015; Geissler et al. 2016; Lachenal 2017). Para-statal and public-private institutions embedded within Sierra Leonean government hospitals continue to conduct research on the biologies and virologic ecologies of the region. Foreign clinician-researchers are often not even permitted to practice medicine within the adjacent general wards, which may remain abysmal—and patients and healthworkers become attuned to this moral and professional economy which valorizes research above the delivery of care (Crane 2013b). The increasing centrality of generalizable "evidence"-production in global health programs, conveyed to clinicians like Tamba as the sense that to run a clinical center of excellence *is* to do more than just deliver care, but also to advance the frontiers of global health science through replicable models and data (Adams 2013), further buttresses this systemic ethical fungibility in clinical practice. This is why, even a clinician like Tamba who was

But I rarely saw Sierra Leoneans—patients or clinicians—express unease at the invasiveness of these procedures, ones that would never be performed by the same cadre clinicians in more regulated or higher-resourced settings. Patients in the Government Hospital (under the care of the traveling humanitarian physicians from America) and in Kisssibanga clinic alike expressed overwhelming gratitude at the attention, the sophistication of the interventions, the possibility of cure. It is easy to fixate on the ethical variability displayed by clinicians themselves, and in so doing efface the brutal reality of how eminently treatable wounds become festering and fatal conditions in a setting like Kono; that a more phenomenological engagement with those realities might lead to a different type of medical ethics entirely.

Experimentality, in Kono today, is not a logic of care that is just brought from afar, nor is it resisted as a lingering residue of colonial medical science. These logics of experimentation are structured into the very Sierra Leonean public health system itself, in which low-cadre nurses are left unsupervised to concoct regimes of care constituted by unregulated trades in powerful pharmaceuticals and procedures in such settings of overwhelming need; to this day, with all of the hundreds of millions of dollars of health aid flowing into the country each year, there is no substantial medical school scholarship program nor term-of-service scheme to train more physicians in Sierra Leone. To rectify or excise the problematic histories and ongoing economies of experimentality within the Sierra Leonean healthcare system requires a more complex politics than some critiques of global health "voluntourism," or geographies of clinical knowledge production, afford.

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attuned to— even obsessed with— the cadre of his clinical staff and structuring his clinic as a delineated hierarchy of workers, might practice medicine without any apparent regard for the limits of his own training.

Ambiguous Efficacy

Tamba's experimental practice was different in one critical way from these other modes of knowledge-generation within Kono's healthcare system and born of the bodies of Sierra Leonean patients: *Tamba simply could not track whether his patients' conditions resolved or continued, nor whether they even lived or died when they returned miles away to their villages and work in the farms and mines.* As I began to realize how fleeting and temporary Tamba's encounters with patients were, my own optimism that Tamba's practices *must* be clinically effective for many patients began to unravel. In other words, Tamba was not just deploying unusual or unconventional approaches to diagnostics, minor surgeries and pharmacology that defied the norms of biomedicine. How could Tamba develop a clinical repertoire if he often never learned the outcome of his interventions, if he could not ascertain whether his techniques helped or not?[1] Tamba's domain as a healer was largely contained within the walls of Kissibanga clinic, which patients traversed irregularly and transiently. Stories would only filter back occasionally from patients' villages once they had left. In other words, Tamba's medicine was an outcome-less kind of medicine.

And would the patients themselves be able to tell whether Tamba's medicines had cured or even helped them? They had often traveled so far to be treated, usually for generalized symptoms like fevers, muscle pain, headaches and coughs, and would return back to the villages and social conditions in which the threat of further illness and even death loomed large. Illness and periodic fevers are part of the ecology: malaria flared up once a month for many patients,

and the sexually transmitted infections would likely recur soon as well. Could these patients delineate the effects of the tablets and injections received at Kissibanga clinic when febrile illnesses were so cyclical and interminable, and when they might supplement their journey to the clinic with trips to visit herbalists and *pepe doktas*? On what grounds could patients determine that Tamba offered, as people in Kissibanga frequently said, "good medicine?" Is "efficacy"—plurally defined—even the right way of thinking through the collisions of patients, technologies, healings, interventions, illnesses, pathogens at play here? Is "good" medicine always "effective"?

Tamba's *bricolage* of clinical interventions were spectacular and sensorial—rectal infusions, tapped abdomens, "intensive care" in the form of bandages, IVs, injections and psychotropics, medicines to make people sleep and make them wake up. All this seemed, at times, more charismatic healing (similar to those offered by healers—more on this in the next chapter) constituted by *process* than a type of healing assessed by its ability to counteract the threat of death, or to eliminate plasmodia or gonorrhea bacilli in his patients' bodies.

I think again here of Levi-Strauss's essay *The Sorcerer and His Magic.* In this piece, Levi-Strauss considers the question of "effectiveness" via a tripartite "shamanistic complex" at play in processes of healing, particularly when the treatment is not necessarily biologically efficacious. The "complex" is made up of the healer, who believes at some level in his treatments; the patient, "who may or may not experience an improvement of his condition"; and the public, who, by virtue of their participation and thus endorsement of the treatment, experience "an enthusiasm and an intellectual and emotional satisfaction which produce collective support." (179). Out of this complex emerges a kind of "gravitational field" between the healer and patient; the group "consensus" on the efficacy of the healer takes on a life of its own, propelling and propagating the patient's own certainty in the healer's techniques. What

deems a therapeutic encounter effective or not, Levi-Strauss explains, is not any neutral, abstract indicator or physiological outcome alone, but rather *consensus* on the efficacy of the treatment. In other words, the healer's therapies are *made effective* through his accumulating and solidifying this collective endorsement—and this, Levi-Strauss insisted, could indeed have biological effects.[1]

The constant, fraught back-and-forth between Tamba, his patients and broader, plural landscapes of knowledges of the body and forms of care, perhaps beg for a way of looking at this "social complex" at play within the clinic as more unstable; to move beyond questions of an "in-tact" efficacy (Adams 2010), to not presuppose a "validation of a system of meaning" in every one of Tamba's encounters with patients (Levi-Strauss 1974). Efficacy, as Vincanne Adams writes, "is a slippery concept" (7)—particularly when most patients are ambivalent about care and ready to swerve to entirely new sources of healing when novel opportunities present themselves (more on this in the next chapter.) Perhaps "efficacy" was not something that Tamba's medicine *could* accomplish—perhaps, all these experiments served more as an iterative body of knowledge on his audience's precarious, shifting, unstable consensus. When one reads *The Sorcerer and his Magic,* one wonders about the Shaman Quesalid's own experimental process: how did he learn to produce a speck of blood in his cheek to spit out? What was it like the first time he captivated an audience of patients? Did he make mistakes in his early clinical encounters? Did word spread of his foibles? In Kissibanga, I was seeing this process play out, just with more transparency given that, unlike shamanistic healing, experimentation and knowledge-production is intrinsic to, and not a liability for, contemporary global health practice. Levi-Strauss's structural formulation of the effectiveness of shamanic healing does not leave enough room for the "unfinishedness" of a healer's techniques. A collective "consensus" on a

healer is not an object *sui generis*, but made up of a collective of patients and their structures of thought, their alternatives, the sacrifices involved in accessing and following through with a healer's treatments. A patient can deviate into and out of that collective consensus, defy or resist it. And in Kissibanga, as I began to notice how many patients left in the middle of the day, or in the middle of treatment, I wondered whether the apparent *demand* for his care, as made visible by the number of patients who lined up in the morning, did not necessarily signify in any one-to-one relation a consensus on the efficacy of Tamba's techniques *after* treatment. Where effectiveness started and ended here, who constituted that "consensus" and what the parameters for it were, are not easy to delineate, and, very well, may have been stochastic.

At times, I was surprised by the outcomes. Once, a young girl who had massively swollen arm and could not feel her hand crudely injected hydrogen peroxide into her arm. I asked her aunt taking her to Koidu Government Hospital. I knew they had the x-ray machine there and Alliance for Health Justice could organize her travel to Freetown if she needed surgery to repair a fracture, and I said I could help arrange the transport to the city. Tamba chuckled, turned to the aunt and translated into Kissi. The woman looked at me, shook her head once and let out a single laugh with an expression like: *Are you kidding? No way in hell that would even be possible!* It was too far, days off the farm, they did not speak Krio and knew nobody in Koidu. The District's tertiary hospital might as well have been in Freetown, or Accra, or New York City—they could not upend their life to travel so far with so little support. A few weeks later, Tamba told me that the girl was doing wonderfully, smiling and happy, and that the arm was back to normal.

But many times, we never heard from patients again after they left the clinic. And some left while waiting for treatment, or before they had received anything at all. It was chilling knowing that a woman with a 14-year old baby on her back, floppy and wheezing rapidly from

pneumonia but who insisted she could not stay for an antibiotic infusion since she "had no diapers" would likely lose her child that night. She had come for malaria treatment for herself, and Tamba had fixated on the baby's problem. In these moments, Tamba would do everything he could to trump up his own knowledge of the situation, to beckon the woman to stay for her child's treatment—and then, as the patient left, pivot into his paranoid explanations of their irresponsibility, backwardness, the behaviors that had brought this on.

The most striking moments in Kissibanga were when we met visibly sick people in their homes on the outskirts of the clinic, who had not even tried seeking care. Even in Kissibanga, where the clinic and the village seemed so fluid and porous, and the nurse so renowned and charismatic—interpersonally, culturally, clinincally—people lived-on in plateaus without seeking Tamba's counsel. One evening, for instance, I was hanging out with a group of ten or twelve-year-old boys. They were coming back from playing soccer, and were enjoying having their pictures taken on my iPhone. One of the boys was squinting; his eyes looked scarred and uncomfortable and he kept scratching out them. The lids were all red and swollen. I recognized this from my medical school lectures as trachoma, a condition that leads to progressive blindness as the eyelids continue to swell and roughen. This boy was well on his way there. And the condition could have been cured with just one tablet of azithromycin, which I knew Tamba actually did have in the clinic at the time.

But the boy just kept playing outside the clinic, slowly and permanently losing his sight, as if there was some wall that existed between him and the drug that kept him from accessing its salutary possibility. Neither he nor the rest of the boys had treated this strange feature of his eyes, that differentiated him from the rest of them, as isolated, alien, pathologized, not

existential—a precondition for seeking out care. Then again—it was so random which drugs were in the clinic at any one time, what Tamba could offer, what he *would* offer, the story he would tell about the cause, effects and treatments for illness, perhaps it never made sense to plan, to align one's condition with imagining the possibility of it simply, truly, going away.

Affects of Global Health

What to make of Tamba's medicine? His clinical practice was, in a sense, a creative archive of the driving if unstated strategies of global health agendas. Tamba saw the pragmatic possibilities in a public healthcare system called "Free," but which had no drugs: entrepreneurship, integrated agricultural financing methods, and a commodified form of medicine enabled through parallel supply chains and pharmaceuticalized care. Managerial acumen, rigid professionalization and hierarchies would make the clinic a model for all others in the region—even when supplies and the infrastructure itself remained decrepit. The generation of experimental evidence could propel the practice, benefiting patients, experts and his own supremacy as a researcher and clinician. Teaching patients to take responsibility for their economic wellbeing and health could resolve so many of the health issues in Kissibanga. Undermining the "backwards" cultural practices, the patient's recourse to "conservative treatment"—without eschewing the occult entirely— could bring development to the community. Rewriting records and generating hundreds of pages of paperwork could ward off the next Ebola epidemic. Tamba rejected the clinical and professional nihilism born of global health managers being conditioned for scarcity. He resisted the naïve misunderstandings of region's social context that are intrinsic to these donor-driven efforts: he called out the absurdity of a Japanese NGO that planted a Western-style toilet at his clinic which

none of his patients would know how to use; he adamantly maintained the importance of taking seriously the witchcraft problem in these villages, and not just dismissing it as superstition. Above all else, Tamba drew on his unchecked, raw ambition make the clinic a Center of Excellence in which these models for financing, structuration, cross-cultural synthesis and collaboration, knowledge-generation and healing would be tinkered with and, ultimately, *scaled up*—that most prized telos of the Global Health Pilot Program.

It is tempting to discount the vacuousness of so much global health today as just sets of "alibis," of fakes, emanating out of centers of wealth and expertise, obfuscating the geopolitical relationships between Kono's impoverishment and mortality rates and those of the Global North. Indeed, paperwork, jargon, enchantingly technocratic visions for harmonized health systems, self-propagating funding schemes and behavior change—all of this does stand in for material forms of care that could alter the real lives and life-chances of people in Kono, and one reaches a point of cynicism that condemning this field with a broad brush at time seems the only answer. And we should call out the vacuities, the injustices, the forms of power maintained by this field.

Global health is an economy of illusions as much as models, logics, alibis and funding, one that extends to the Kissi Triangle forest and a tiny village on the border with Guinea. But these illusions are more than just *fakes*; they do not fall flat or fizzle out amidst the absent resources in Kono. Following David's evocation, once again, of the invasion of Aberdeen Beach, these illusions are "seen" even if they are "not meant." These illusions are affectively potent for they affirm a possibility that healthcare can be made *great* without structural transformations in the financing, staffing and supplying of the Sierra Leonean healthcare system. They are affectively potent for the health funders and NGO directors relentlessly committed to a neoliberal "answer" to health inequities; for a striving clinician thrust into building a clinical

empire with little drugs, supplies or mentorship in Kissibanga; and, at times, for the patients who rallied around the "Well Known" and "Ambitious" nurse posted to the clinic who would *put things in order*.

These illusions, the possibilities and turmoil they engender, seep into interpersonal relations between nurses and nurse-aides; into traditional healer unions; they propel chiefs to proclaim their villagers' primitiveness in the forms of care they seek out and those they reject; they penetrate the homes of Ebola survivors where people, with a kind of split, melancholic tone, explain their contracting the disease as born of their own ignorant behaviors. The illusions of global health come to structure relations of and to care, sociality, to life and death. They form the backdrop to therapeutic worlds in places like Kissibanga, though never completely, for, as João Biehl and Adrian Petryna write (2013:10) "people navigating health and humanitarian interventions and their aftermaths can also produce breakthroughs that demand recognition."

Indeed, beneath these optimistic-if-hollow illusions, again, there was the thinly-veiled arbitrariness to it all: who made the trek to Kissibanga and who didn't; who got better and who did not; what behavior Tamba would fixate on to piece together the causality behind his patients' bodily breakdown; which of his techniques might help and which would be at best impotent and at worst dangerous; at what point a patients' pain or discomfort became something worth traveling to Tamba to address, and what, like that boy's eyes, remained just a feature of someone's body in a state of chronic debility and poverty. Perhaps this was what that threatening Vaccinator had picked up on after his many years of observing from the corners of the clinic: Tamba's simultaneous certainties, the promises he made and harnessed, and the impenetrability to what he prescribed and what his medicines actually did. Beneath all the bluster, it was truly

unclear who Tamba's care actually helped, what it helped it with, at what point patients left the clinic, and whether or not they would come back.

These two poles—the optimistic illusions, and the arbitrary—resonate with the other domains of social life covered in this dissertation, and perhaps, as a structure of affect or withdrawal, is itself something of a Total Social Fact: the oscillation between the intoxicating possibility of the diamond mines and the *settling-into* the randomness of it all; patients' swerves to and away from lifesaving care; the spectacles of humanitarian incursion and the nonsensical spread of death beneath it all; the possibilities afforded by Prosperity Gospel Pentecostalism, and the random, almost whimsical running-over of a five-year-old brushing his teeth on his stoop. Here, I could see more clearly how these two poles were linked. The surges of optimism and intensity emanating out of Tamba's clinic and practice drew patients, offered a kind of direction for their movement in a world overwhelmed with capricious illness and death. But in Kissibanga, with all this vision, promise, and sense of possibility about things working in the clinic, in the end, for many of his patients, they did not seem to work. There was always that possibility that Tamba could save someone's life or resolve their suffering—and that's why people came—but Tamba's optimism and his medicine often did very little to counteract the ongoing possibility of illness and death, or even patients' embodied debility.

In Kissibanga, in moments of a certain type of clarity, or perhaps just worn out by the accumulated incommensurability between these optimisms and the ongoing realities of embodied and precarious life, patients detached from this nexus of promise, clinical authority, techniques of healing and perhaps even hope— and, withdrawing, refused it.

Chapter 7: Bad People

As the Koidu Government Hospital, with its new NGO partnership, expanded in its "systems, staff and space" (Farmer 2014), and amidst all the fanfare about the patients now coming from afar to seek help from the *formerly*-decrepit facility, another center of care was going up on the outskirts of Koidu. By early 2021, everyone in town seemed to have heard of the Kuranko man named Bakarr who had moved his healing compound to a large parcel of land abutting David's property. What had formerly been a quiet tract of elephant grass that motorbikes feared to travel to after dark now was full of people, of all social classes, day and night.

David had been meaning to greet his new neighbor for some time. It would be important to have a good relationship with the medicine man, he told me. Even someone like David who considered himself "skeptical" would not want *juju* of this power directed against him. But consumed with his own health problems, and perhaps feeling some trepidation, David had watched the compound grow and the clientele multiply throughout the year from afar. Then, one day, he found Bakarr drinking a sachet of gin with his brother, and introduced himself as a neighbor. "I told him I might have a white man who would be interested in learning more about his work—that I did not know why, that it would be left to the white man to explain what is mission is. And Bakarr said 'Yes, no problem.'" But then, David told me, as he was leaving, Bakarr muttered to himself: "'Those white men, you must be careful of them! They are always trying to take what we have!'" [55]

[55] Recall what Zora Neal Hurston wrote of her interlocutors' refusals to reveal the folktales they lived by: "The white man is always trying to know into somebody else's business. All right, I'll set something outside the door of my mind for him to play with and handle. He can read my writing but he sho can't read my mind" (Hurston 2008:3).

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Just off the dusty red-earth road that swooped past David's farm, up a steep embankment abutting the forest, Bakarr's compound was marked by a towering bamboo stick from which hung a white flag and a bottle. One large, unfinished concrete house stood to the left with a sheep skin tacked on the wall. People of all ages milled out front. Behind it, I saw a structure made of UNHCR tarpaulin and stitched-together rice sacks. In the middle, there was a round concrete hut with a pyramidal thatched roof. In place of a door, a white and red cloth flapped in the wind, revealing glimpses of a shrine of computers, calabashes, konsoo beans, bottles and other fetish objects. A dozen or more people sitting quietly on the verandas, stoops or prayer mats on the ground watched me. I greeted them to nods. At my feet, I noticed the tops of three, empty glass beer bottles, buried until their openings were flush with the ground.

"This is the man, Bakarr," David pointed with his crutch. A bald man, not more than 25 years old, walked towards me distractedly, holding a phone and with a throng of people around him. He wore bleached, tight jeans, a fashionable t-shirt and a small purse slung diagonally across his chest. His Traditional Healer's Union ID hung around his neck,[56] and his phone rang constantly. He shook my hand between phonecalls and led me into the round hut where I sat

[56] Throughout my research with Bakarr, there was certainly no evidence that the Union had any control over his practice, despite his wearing the ID card proudly. In fact, when I interviewed current Union leadership, they expressed frustration—or perhaps jealousy—of Bakarr's success, saying, "Trust me, he'd be nothing without us!" One time, while I was at Bakarr's compound, a current Officer came by to meet with Bakarr and saw me observing there. Officer and Liberian said they heard the man telling Bakarr not to trust me, and Bakarr quickly became reticent to interact. Officer and Liberian broached the subject with Bakarr—if that man had said something about me, if I had done anything wrong—and Bakarr quickly shifted his tone. He said that the man was deeply jealous of his work and acclaim, was threatened by my attention, and wanted to drive a wedge between us. Bakarr would not allow this jealous to fester, he said, and had weapons at his disposal if this conniving from the Union escalated.

down on a bench on the side. His assistant, Mohamed, another young man in his early twenties dressed in tight and fashionable clothes, sat on the side of the shrine.

Bakarr made piercing eye contact, and his rushed speech made it hard not to feel sucked in. "You understand, *you understand, so you see, eh?*" he finished each clause, with increasing tempo. There was a sense of being trapped in his language and scrutiny. He told me that he had come Falaba District, the Kuranko territory, on the Northern border with Guinea. The devils had come for his mother when she was pregnant. They told her that they would come again for her son who would have a gift, and that she should not resist when the devils tried to take him away. They came when he was five and took him to the bush for five years. There the devils taught him to read, to write; there he learned Arabic and the leaves to use for medicine. He had been doing this medicine work since he was a child. A few years back, he had moved to Kono to set up a small compound nearby. Word of his skills spread; many people told stories of how he had helped them. Then, he had met with the Chiefs to find a bigger place to expand his compound and been given this land in Daama. His new space went up quickly, and now there was space for 2 or 3 dozen patients to stay and undergo long-term treatment. The devils now called him on the cellphone he always held in his left hand to consult on patients and medicines. "

How often?" I asked.

"Tuesdays and Thursdays." He said they called earlier that week to let him know that I was coming, "that this was *sababu [*chance*]*….I didn't go to school, I didn't learn. Now I speak Arabic, now I read. I know leafs. *This is all devil.*" Suddenly, during the conversation, Bakarr looked off away from everyone in the room and spoke quickly in some other language. I heard the term "White man."

His assistant, Mohamed, leaned over to me—"*he's speaking to his people, his devils in Arabic."*

"Ok, ok," Bakarr said at the end, nodding into space, and turned back to me, as if nothing had happened.

He led me outside. Behind the hut, dozens of large iron pots, blackened from coal and stuffed with leaves, sat on smoldering fires tended by women whose skin was plastered in the mud and herbs. Off to one side, patients, covered in blankets, sat over large holes in which leaves smoldered smoking themselves. Patients called to Bakarr as we strolled through the complex, asking questions about whether they were properly mixing the medicine or when he would see them next. He had the air of a high-level manager, overseeing a large and organized operation, if also a bit overwhelmed.

Behind the central compound, Bakarr's men had made clearings out of the lush forests where patients, clustered in groups, lay on matts: some shifting, clearly in pain, others listening to music or chatting in small groups. The waiting in these little micro communities of patients and families undergoing treatment reminded me so much of the Government Hospital wards, but there was a peace at this place, devoid of the frantic and painful energy. There were no screams or wails punctuating the waiting. Men, women, old and young, people who spoke only in Kono or Kuranko and young professionals from Freetown—I saw them all that day as we toured the clearings and glades and I wondered whether the NGO workers so emphatically proclaiming about the "progress" at the Koidu Government Hospital development project had any idea what was happening back here in Daama.

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Nearly every day for six weeks I took the back paths from David's property, through the quiet village of Daama, to Bakarr's place. The paths abutted the glades, showing glimpses of the patients waiting, cooking or nursing their wounds through palm-fronds and bushes. David said that the sight of smoke rising from these little settlements shrouded by bush in the misty mornings reminded him of the camps he and others stayed in while fleeing the rebels during the war. Transient solidarities were forged in those camps, when different people's lives and care briefly intersected and everyone counted on each other to raise the alarm when combatants were spotted. The bush is an ambiguous, dangerous space in Kono, and people often clear the brush and trees quite dramatically around their houses to keep out snakes and devils. Older Kono had mentioned to me over the years how the younger generations now see the forest as just something to conquer and make money out of. All of the historical prohibitions— on logging, sex, drinking— to protect the sanctity of the forest and the devils therein, now went unheeded. So I wondered about Bakarr's vision for this healing compound-cum-camp, that offered such a different backdrop for domestic space from those from which many of his patients would come. Might it have served to conjure memories of the war-times and the life-or-death relations of concern with strangers? Or perhaps the lush and moist forest was something of an aestheticized vision for the healing he practiced; a type of care that he, adamantly insisted, consisted only of leaves from the bush?

My second day at the healing compound, Bakarr waved me into a glade around which a tarp had been hung to obscure others' views. A muscular man in his thirties lay prone on a cloth in his boxers, and Bakarr and his assistant, Mohamed, studied the man's back. Bakarr rubbed his finger, delineating a spot, as if he were feeling for something beneath the skin. The assistant

nodded. Bakarr then took a needle and a razor blade and carefully worked to thread the needle through a tiny piece of skin, pulling the skin taught over the point of the needle with the help of the razor. He edged together the rusty razor and the needle again, until something happened, and the needle seemed burst through the skin. Bakarr pulled the needle upwards; the man on the ground sucked in air. Bakarr pointed at the man's skin, white over the tip of the needle. "You see this?" he asked me. "This is thread." It was the net that the witches had shot and tangled the man in. The needle tore away from the skin. Bakarr took a green paste from a little tub and dabbed gruffly where the thread had been pulled out.

Bakarr and his assistant performed this process again and again. They worked off of each other—the assistant feeling for a thread with his fingers, then pointing; Bakarr confirming and nodding, and vice versa. "*Luk ya! Luk ya!*" one would say to the other while pointing at an area of the back that looked to untrained eyes indistinguishable. And the other would nod and begin to feel with his own fingers. Bakarr, at times, took a cone-shaped stone tool that looked like an ultrasound probe and pressed it lightly against the skin while looking up to talk to me. This was to draw the net to the surface of the skin.

The man on whose they had been working turned to me after the session was over. "I am feeling much better, thank God." He told me he was a police officer, and had travelled all the away from Freetown to meet Bakarr after hearing of him from his boss's wife. "Many people say this man helps them," the Officer said, "he is really trying to help people, and he is now helping me." The pain that had plagued his lower back and legs had gone on for months. He had been to the hospitals in Freetown, private clinics, they had done x-ray after x-ray but no answer. It was difficult to stand up straight, for four months he took so many injections. He had tried the "English way," now he wanted to give the "native side" a chance. So he came to Daama, and the

pain was so much better, not like before. He felt different. “This guy is very good,” he said, “especially with this, our black magic business.”

The Officer had been to other medicine men, and his body was covered in little linear scars on his legs and arms, like an archive of past herbalists’ witch bullet and thread extractions. Maybe some were quacks, maybe some just weren’t skilled at taking out the thread buried under his skin, that is left to them to know, the Officer told me. But when he had come to Bakarr, the healer had said immediately that the problem was indeed the “bad people” and that the Officer had been shot and tangled with a net. “This man here is really trying, he is really helping people,” he said again, with a quiet earnestness. “Thank God.”

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I got to know Officer well over the next weeks. He had come a few days before I met him undergoing the net extraction. He in turn had become friends with another man in his thirties, who we all called Liberian, who had arrived about the same time. Liberian was a short, gaunt man with an angular face and a similar quiet pensiveness about him. He had similar symptoms, pain up and down his body, but the discomfort mostly centered his groin and upper thigh. He was born in Kono but had lived most of his life in Liberia and spoke *Krio* and English with a strong Liberian accent. He had been a soccer player before the pain had started, and had traveled to herbalists, hospitals and clinics across Liberia and Sierra Leone. The last place he had gone was the Koidu Government Hospital which, while impressive with its facilities and staffing, did not offer any answers. Bakarr had told Liberian that he had been shot with a net as well, and he

had gone through the same extraction procedure as Officer. Liberian was so happy and proud to be with Bakarr, who he was sure would cure him of this sick.

On the first day, they told me, each one met with Bakarr in the hut and offered some money. They signed a 10,000 Leone note as a commitment, explained their story, and Bakarr asked for an act of or charity: maybe a chicken for the children from the village to eat who are always around. "The charity helps you have a chance," Liberian said.

Then, Bakarr asked the devils if the problem was due to bad people. "He looks at your situation and the disease, and uses his instruments to consult the devils in front of you. He asks, 'Is this sick from bad people?'" His instrument, an Ovaltine jar with a modified lid, started to spray water, and that was the answer: this meant that *yes*, the sick was from bad people and the devils would help Bakarr in selecting the leaves to treat him.

The second day, Bakarr took them to one of the glades where he and the assistant extracted the nets with the needle and razor. This was painful, but gave enormous relief afterwards. That night, they washed their bodies with water from the boiled leaves and applied mud on their skin mashed with leaves.

On the third day, they were given Bakarr's signature medicine, one that he called *lalapinta*. This made them sit all day in the forest "shitting and vomiting and wanting to die." Some of the patients I saw in the glades were on their *lalapinta* day, and looked miserable, staring at the ground, retching and choking. Patients would laugh and yell encouragement at them: "*At the end you will feel so good!"*

Then, the patients would wait, for many days, applying the leaves and mud to their bodies, smoking their bodies and washing themselves with warm water boiled with leaves.

The patients cooked their own food, but Bakarr gave them a place to sleep for their treatment. He even slept with them in the same area, a sign of his humility and commitment. He charged great fees but was generous with passing out small amounts of money when patients needed to go to town. He even offered me money for my own transport sometimes. Once in a while, Bakarr would perform magic tricks to entertain the patients and impress upon them his powers during their treatments.

One time, he announced to everyone that he wanted to turn leafs into money. We all sat around him as he ate a folded leaf, and washed his mouth with water. Then, after rubbing his mouth with his hand, a folded 10,000 Leone note appeared in his palm. Everyone clapped. "*Yu nar rich man*!" I yelled, giving him a high-five.

Bakarr furrowed his brow and yelled at me, "*Nɔ! A nɔ de wich.* [I'm not a witch!]*"* Someone else jumped in to explain that I had meant he was a *mɔni man* [money man]. I had gotten my *Krio* vocabulary mixed up. Bakarr smiled, slapped my hand:

"Yu yɛri?yu yɛri? Mɔtalman difrɛn!

Wetin yu de si, a nɔ de si!

Wetin a de si, yu nɔ de si!

Wetin in de si, we nɔ de see!

Mɔtalman difrɛn!

[You hear? You hear? *Mɔtalman* is different!

What you see, I don't see!

What I see, you don't see!

What he sees, we don't see!

Mɔtalman is different!"]

*

I sat one morning with Officer and Liberian under the shade of the thatched round hut. I had brought them some beef from town; they were missing their wives and children and wanted to make some soup with the meat, and they had hung it under the rafters. The smell was turning rancid, but they said they were excited for their feast that evening.

They both told me about their journeys looking for care, what had made them end up at Bakarr's place. We just want cure, we just want cure, they kept repeating. "When you have a problem with our health, it consumes your whole life," Liberian said. "You just want cure, we both need cure." Everyone at the compound used this term, one I had not heard before at a healer's compound. This was not a place to seek out plateaus, making-do, living-with-the-pain—they wanted to be rid of these discomforts once and for all.

The conversation shifted to the state of the country. Things were getting worse each year. The COVID-19 outbreak had played a part in the economic collapse, but the price of rice and fuel had skyrocketed as well. The new President had ceded to pressure from the donor community to cut public subsidies on food and fuel, and the Leone had dropped in value. People weren't going to bars, weren't dancing, many were hungry. The Leone had lost more than half of its value in the past decade. Things were tense, politically, as well. The President, a former soldier, seemed to have taken heed from some of his authoritarian predecessors and had begun to crack down on dissidents. A movie had circulated that week of members of the Presidential

Guard dancing and talking about how they would massacre protestors. Someone had been stabbed to death in a political squabble that week in Koidu, there were riots in Freetown between motorbike riders and the police. “The country isn’t steady,” Officer said, and they were both worried about being away from their families.

The conversation lulled. “Who do you think shot you with the weapon?” I asked.

Liberian answered first: “Well, I was a football player, so you know I come across many different people, shaking their hands…”

I turned to Officer and asked him the same question.

“I don’t know—you know I am a high-ranking sergeant, so maybe someone from my workplace,” Officer said.

“Don’t you want to know?” I asked.

Officer paused. “Yes, I want to know, who did this, who caused me so much pain. But you know, if I know, maybe it is someone close to me, and there will be chaos.” Liberian nodded.

I asked them: “If someone close to you did you so much harm, wouldn’t you want to cut them out of your life?”

“The solution is not to drive them from my life,” Officer said. “It’s to protect the body so if they try again, they can’t.” At the end of their treatment, Bakarr would make them charms to ward off future harm. Liberian added that the whole thing could just be a matter of bad luck: someone could set a trap on the ground for someone else and you can step on it, so it could be totally irrelevant who set the original curse in motion. Better to just double down on protection than upend your life looking for those who harbor ill will against your “star.”

I was perplexed: "Would you really want to remain friends with someone who would hurt you like this?" They were ambivalent about my portrayal of the certainty surrounding the situation. Some people act as witches even when they don't know it, they said.[57] The threat of jealousy, conniving, violence, illness was all around them, it could erupt at any moment. The threat was inescapable, it could not be excised or exorcised. You learn to live with it—even your best friend could seek to harm you given the desperate state of the country these days.

I asked another question that had been on my mind: "Do you think these leaves are themselves powerful like devils? Or the devils merely instruct Bakarr in how to cure, how to provide protection, the leaves are like tablets?"

Both were emphatic: the leaves were leaves. Bakarr had a gift, an "eye," he could help see the evil in the world and the devils instructed him on what objects to use to fight it. So I asked if some of Bakarr's patients might have purely medical problems, not magical ones. "Of course!" Officer said, "but leaves are like pills, so there is no reason they can't help with that too."

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[57] The term "witch" in Krio is itself an ambiguous one, making difficult any claims to certainty about the agency of the accused. Witch can refer to an alien substance that an evil person has put in someone's food, thus making them unwittingly perform evil. Having "witch" can also refer to having an "eye," that is, the capacity to see and intervene upon occult forces—even to heal. And "witch" can also refer to a person who has decided, because of agentive evil, to turn to *juju* to cause harm and kill. An *accusation* of witchcraft, therefore, is a statement about the omnipresence of antisocial intentions and evil in the world. But it is not *necessarily* a statement about the character of the accused individual. That individual him or herself, after all, may have been fed "witch" by someone else.

While many systems of witchcraft accusation and persecution do rely on certain forms of diagnostic certainty so as to excise the threat from the social fabric, Evans-Pritchard's account of Azande beliefs briefly mentions a similar kind of ontological uncertainty. "In speaking of witches and witchcraft it is necessary to explain that Azande normally think of witchcraft quite impersonally and apart from any particular with or witches….he speaks always of *mangu,* witchcraft. This force does not exist outside individuals; it is, in fact, an organic part of them, but when particular individuals are not specified and no effort is made to identify them, then it must be thought of as a generalized force." It is too simplistic to say that witchcraft is merely abstract, for, when one probes, the concept of witchcraft is always tethered to an individual; but this constant dynamic between the personal and impersonal, between knowing and not-knowing, characterizes the ways that the threat is experienced and spoken of. Evans-Pritchard continues "The concept of witchcraft is not that of an impersonal force that may become attached to persons, but of a personal force that is generalized in speech." (13).

He wanted to cut off the conversation—he seemed uncomfortable with speculating. “But really—this is best known to Bakarr.”

*

In my prior experiences talking with patients in the hospital and who had visited other healers, I had never heard patients insist on maintaining this uncertainty surrounding the perpetrator of their conditions. Ramatulai and Fidel’s other interesting patients had not named their conditions beyond “sick,” but this was different. At Bakarr’s compound, the patients were certain that their conditions were caused by witch. But so resigned towards the constant proximity and inevitability of “badness,” they maintained they would rather not know who was harboring so much jealousy and evil to cause such debilitating pain.

Over my years in Kono, as the optimism of post-war possibility in the country waned and the economy continued to falter, I had noticed that abstract threats to life, property and personal development seemed to dominate conversations more and more. People in Kono spoke frequently about the problem of thieves, and invested much money in charms, barriers made of shattered-glass and barbed wires to ward them off from houses and farms. The witchcraft problem had gotten worse, many people said, for “witches don’t like development” and, as urban poverty had worsened, desperate people were increasingly driven to jealousy and evil. People complained about the problem of “cliques,” or “clique-boys,” groups of idle and unemployed adolescents, unconstrained by norms of respect and sociality, who acted like gangsters, roaming around, robbing and terrorizing the local communities. A group of middle-aged ex-soldiers had begun to patrol the towns to root out the cliques. I never met anyone who had been attacked

themselves by a clique, but had heard many emphatic stories of other people being robbed, beaten or even raped.

In 2021, conversations in coffee shops, palm wine bars and even columns in local media centered on a new scourge. The clique-boys were not just stealing and smoking *djamba* and *kush* to pass away their wasted time, or stealing or turning to witch-guns to assassinate people for hire. They had discovered a new drug that made them high and violent: boiling diapers, both dirty and unused, and drinking the water (Williams 2020). "You can see these boys go to the market, age 15 or 16, and ask for bags and bags of diapers!" one man had explained to me in Freetown. "All to make this *pampas tea!*" Opposition candidates used this pathetic and dejected image to speak of the failed prospects of the country's youth: *pampas tea* signified just how desperate the next generation had become, how lives were wasting away amidst the abjection (The Calabash Newspaper 2020). I never saw anyone prepare this concoction, never spoke to anyone who actually saw the boys buy the diapers. I inquired in the market, I spoke with stoned young men in the *djamba* ghettos, the very ones who everyone was accusing of guzzling this foul new substance. The answer was the same; an unspecific but certain: *"Yes, people can do it."*

Direct accusation and confession, in this context, is risky. Social relations in Kono are fragile; there is, after all, a very concrete recent history of extraordinarily intimate violence during the civil war. No matter how much people reference the message from the country's Truth and Reconciliation Commission that was projected to all corners after the war— "forgive and forget!"—I have always wondered what it's like to wonder whether the motorbike taxi driver who has your life in his hands may have amputated your cousin, abused your mother, killed friends and kin. The people are still here: what was it that emerged in the 1990s, and could it come out again? Perhaps it *is* there, it never went away, and with the automatic weapons and

machetes laid down, traps, *fangays,* witch nets and boiled diapers have been taken up. Perhaps it has even amplified amidst the growing malaise, the unfulfilled promises of postwar politics and humanitarian care, the increasingly bleak economic situation facing most young people who have migrated to urban areas, for whom, as Ghanaian-American scholar Ato Quayson writes, just finding things to pass the time and not be overwhelmed with boredom may constitute the great struggle of everyday life (Quayson 2014; see also Masquelier 2019). To desire to much specificity about a transgression in these conditions, David once told me when I asked why admitting guilt is so taboo in Kono, to demand or offer a confession, "will just seem to be escalating things, and that can turn into something else entirely." And perhaps this displacement and externalization of violence is itself a kind of ethics; the living-with the omnipresent "badness" and "bad people" an articulation of a collective condition and the shared struggles for livelihoods, security and sociality.[58]

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[58] I have not found ethnographic literature on witchcraft in the region that resembles the forms of threat that Officer and Liberian recounted. Accusation and confession seem to dominate earlier accounts (Jackson 1975). Thus, it is possible that this living-with is born of the recent history of the war and impoverishment. However, many anthropologists have written of the "cultural order of secrecy" and the "hermeneutics of suspicion" (Ferme, 7) that characterizes the region's social order and that certainly plays a part in how these notions of etiology are insinuated as well.

Beryl Bellman, for instance, an anthropologist of the Kpelle Mende in Liberia, traces this "adumbrated" manner of accusation to esoteric cultural institutions in the Mano River region rather than geopolitics or economics. Bellman was initiated into the Poro sodality himself, and maintains the most important part of initiation is the training in a manner of adumbrated communication that maintains and even proliferates the specter of secrecy and suspicion. For instance: the initiates are scarified early on in the initiation on their faces and backs, which is explained to be due to the devil's teeth when he "eats" the initiates, killing them and enabling them to be reborn as Poro men. But, as David (a Poro member) once said to me in his own adumbrated (though certainly unsanctioned) way: "You cannot have smoke without fire, you cannot have a scar without a…" Mothers are told that their children have been killed by the devil and will be reborn as *Poro* members, but see food, oil and rice being brought to the initiation bush throughout the liminal period of "death". These registers of performance are actively maintained on all sides, and, as Bellman writes, "if a boy is hesitant in affirming the metaphor, the members persist in chiding him until he does" (108). The initiates learn—but never explicitly, more via demonstration and apprenticeship— the proper adumbrated way of speaking to different people and in different situations.

One old man, well-known as a keeper of Kono history and folktales, once said, somewhat: "Poro is like when a seller takes a cup of water and pours oil into it. You then look down at the cup and all you see is oil." The insinuation—as analogy—was that there is no "there, there." But a group of men will never, ever voice what is "there" and what is "not"—that is left to them and their interior selves to discern. "The contents of the secrets are not as significant as are the *doing* of secrecy and the recognition that a do-not-talk-it proscription Sia feature of all legitimate social interactions," Bellman writes. *Poro* is a "language of secrecy," a training in concealment. This

Nigerian-American novelist Chris Abani describes a similar mode of collectivizing the perils of predation and violence—almost through a kind of compassion— in an essay on his childhood, the political violence he experienced in Nigeria and the ethics of intersubjectivity that it engendered:

> A lot has happened between then and now. A lot of blood…The thing is, my knowledge of blood, of the terrible intimacy of killing, has taught me that though I have never killed a man, I know how, I know I could. The only thing that terrifies me is that I may not feel sorry. And even as I make this terrible confession, what can it mean? What does the moment offer? Affirmation of something already suspected? Or something else, the recognition perhaps that we all stand at the edge of the same abyss? (Abani 2009)

Perhaps the slippery slope to violence in this context—the omnipresent possibility of enacting violence as a kind of commons—was the flipside of what David was getting at too, in that conversation on the beach after I met Peter and heard about his brother's deadly accident. One doesn't need to make so much meaning out of these proximities to misfortune and violence, he had seemed to say, for they are inevitable in this world. I reproduce here his response to my inquiring about whether religion helped answer the question of "Why me?" in a world wracked with contingencies:

> I'd just think that if something bad were to happen to me, it had to happen to someone, and it could have happened to another person who would have the same feeling as me, so why get so concerned about "why me?" It happened to me because it did, and if not me, someone else would be feeling it.

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analogical, adumbrated form of language breeds a state of constant uncertainty about the Other, what he knows, what he is capable of.

Thus, such familiarity with adumbrated epistemologies of accusation might constitute the cultural context through which these commentaries on foreclosed futurities morph into the type of *living-with* that Officer and Liberian described.

There were three types of patients who ended up staying at Bakarr's compound, sometimes for months on end. The first were those tormented in various ways by devils. *Kres man* chained to logs or to themselves, a young man who had ceased speaking clearly and erupted into spastic fits, two teenage girls tricked into coming from Freetown to Bakarr when their mother dreamed that they had been poisoned with witch food and now possessed witch, and were acting strangely. With Quranic recitations, some beating and lots of *lalapinta,* Bakarr could fix all this.

The second were those with long term, systemic, chronic conditions—patients like Liberian and Officer. There were women with ulcers, men with joint pain, and many of all ages with back aches and terrible pain in their stomachs. All of these people had been shot with nets, witch guns, or caught in traps.

The third were patients with severe physical symptoms. Festering wounds and sores and swollen gums and teeth, but also even stranger-looking things. One girl was covered from head to toe in blistering vesicles, crying out in pain (this was *nyangafo,* a dreaded sickness caused by a magical powder blown on the victim. The girl was isolated in her own glade so the powder would not get on the other patients.)[59] A man limped around with a huge bone tumor erupting out of the skin on his thigh, dripping pus. There was another man who had felt feverish and then

[59] I took photographs of this girl's skin condition and sent them to a dermatologist friend, who recognized it as likely an extremely rare autoimmune condition. I brought the pills from Freetown and we secretly gave them to the mother, who was eager to try them but did not want to leave Bakarr's complex. While the girl continued to have mud and lime juice matted on the skin she also took the medicine each day, and in one week the eruption completely resolved. Bakarr had his own medicine validated; the mother seemed inclined to think it was the tablets but could still say she went ahead with Bakarr's medicine; the girl's skin completely transformed. In 11 years in Kono, this was the first and only time that one of these efforts to bring unusual medicine for a rare condition worked without a hiccup, and the girl has returned to school and says she will continue taking the medicine each day.

gotten better, but now had a rapidly ascending paralysis and, by the time I met him, could not move his legs at all.

Every one of these patients with physical symptoms—chronic and the more unusual ones—had gone to the NGO-supported hospital before turning to this local medicine men. In fact, some had traveled from across the country to Kono, it seemed, because of the NGOs' publicity about the newly-renovated Koidu Government Hospital. And everyone had been seen once, or sometimes several times, by the nurses there and then dismissed with no answers and a confusing regimen of tablets and injections. Some of these patients showed me their discharge papers. The man with the erupting thigh tumor had shown the tumor to a Community Health Officer who had ordered an x-ray, just noted "reduced bone mass no fracture" and then sent him away. The girl with the blisters had been told she had "cold" and "typhoid-malaria" and given one unnamed injection. Many of the discharge papers offered no diagnoses; other patients had been given explanations that seemed remarkably similar to the types of language used by Bakarr and other herbalists. The man with the paralysis had been told that his food was not digesting clearly, sitting in his stomach, and that he had rheumatism and typhoid. (This was during an ongoing polio outbreak in the country).

Over and over again the patients repeated that they had been told at the hospital that they had typhoid-malaria, that they had "cold," or that the blood was pooling in the vessels in unusual ways, or other tangible, if dubious, ways of locating sensation in concrete structures of the body. I thought of the American clinicians I watched over the years who would become so frustrated with HIV and other chronic disease patients not taking their medicines each day. For these patients, the expatriate physicians' language of the body being a biological machine that needed

to be "kept-up" by swallowing pills even when the patient felt fine often did not make sense.[60] It was always a challenge to convey a notion of lifelong disease and treatment that had to be maintained with drugs. And here, the government hospital and NGO nurses certainly seemed to have offered patients much more concrete, comprehensible models for their diseases—pooled blood, blocked vessels, food sitting wrong in the stomach. But a model was all they offered; there was no cure.

So one by one, the patients bounced—that was the verb that came to mind—from the hospital, and ended at Bakarr's where they were told: *no, this is not just a problem of fluid collecting in vessels. This is witch.*

One time, I followed up on my earlier conversation with Officer and Liberian. "If the leaves are just medicine that the devils direct Bakarr to apply, why do the devils only tell him to use leaves? Why don't they direct him to, say, give tablets? Why do devils, if they really are just teachers, only offer leaves?" Amidst all this syncretism, I was confused about why the devils seemed to adhere to such a stark binary of "native" versus "English" medicines.

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[60] In *A Dying Colonialism,* Fanon describes this situation: "The doctor has no hold on the patient. He finds that in spite of promises and pledges, an attitude of flight, of disengagement persists. All the efforts exerted by the doctor, b his team of nurses, to modify this state of things encounter, not a systematic opposition, but a 'vanishing' on the part of the patient. The first thing that happens is that the patient does not return. This is in spite of the fact that it has been clearly explained to him that his ailment, in order to be cured, requires that he be examined several time at given intervals. But the doctor waits for him in vain. The patient does not arrive. When he does come back, there is the rather shocking discovery that the malady has become very aggravated….The sociological theory is that the 'native' entertains the firm hope of being cured once and for all. The native, in fact, sees the ailment, not as progressing little by little but as assaulting the individual in a single swoop, so that the effectiveness of a remedy would not depend so much on its consistent, periodic and progressive repetition but on its total impact, its immediate effect; this accounts for the natives' preference for injection. According to this theory, the doctor would always have to heal at a single setting. …this explanation surely contains an element of truth. But it seems to us, to interpret a phenomenon arising out of the colonial situation in terms of patterns of conduct existing before the foreign conquest, even if this phenomenon is analogous to certain traditional patterns, is nevertheless in certain respects false." (129-130)

Officer threw up his hands: “You asked us this before—that is best known to Bakarr!” The cartographic certainty I sought was simply not something Officer could claim to provide. He was there for cure.

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A few days later, when I met them, Officer and Liberian’s mood had changed. They were frustrated and ready to go home. “This man is good at treating people in the beginning, but then he stops giving you attention,” Officer told me. The pain had continued, both had realized. While we were talking, a woman came through the glade who introduced herself as a Maternal and Child Health-Aide. She came through each day to give medicines discretely to Bakarr’s patients—those who needed help with the “cold” of living out in the bush for long time, but also, it seemed, for those who were growing skeptical of Bakarr’s treatment. She pulled out of her plastic bag a box of injection vials, loaded them up in syringes, and one by one gave a group of patients shots of pain medicine and antibiotics.

“Sometimes, after you leave, we think about your questions!” Officer told me. “They make us think! I see what you’re getting at, it’s helping us see reality.” I felt sheepish at being characterized as some sort of investigator or sleuth—I was not trying to undermine Bakarr’s work, and wasn’t even sure myself what I was “getting at.” “Like—why is it that *everyone* who comes here is told that they have a witch problem? Certainly not everyone has a witch problem, some have a medical problem. We did not think of this before, but now that we do, we realize—he must be telling some people with medical problems that they have witch problems.” I tried to

look ambivalent, uncomfortably aware that my encounters and questions were already having effects on Officer and Liberian's relations to Bakarr and to their own embodied conditions.

I asked, "Do you believe that you have a witch problem?"

Officer responded first: "It's really complicated. When he interviews other patients, it's always witch witch witch witch, nothing natural. But what you don't know you cannot deny or accept 100%."

Liberian added: "When something is pressing you," a problem like this, anxiety about such a problem, "it takes over your life."

I asked them both about Bakarr's diagnostic process with the Ovaltine jar. When we had spoken before, that *did* seem to suggest that Bakarr had sought guidance from devils in diagnosing their conditions. But Officer had had second thoughts about this as well. "Bakarr doesn't actually ask the devils if it [specifically] is a natural problem—he just asks, 'Are there bad people trying to hurt this person.'" Who doesn't have *some* bad people trying to hurt them? The devils will always, therefore, say 'yes.'"

There was a pause.

"But Raphi, we are wondering…what do *you* think of our conditions?"

"I—I am no doctor."

"Yes, I know, but you must have some thought…."

I paused, trying to think of how to respond. "It's hard to know. Some people just have pain. In America, people become addicted to drugs to make the pain go away. Sometimes the pain is the muscles, or the joints—you won't see it on an x-ray. And people have to just live with the pain, there is no answer to be found." After I spoke, I realized how similar this idea was to that which Liberian and Officer had told me when they insisted that they did not want to know

who had attacked them by witch, but just to live with the uncertain threat, that baseline precarity and pain.

"That is what I was thinking," Officer finally said. "Perhaps you might have some pain tablet? One from America?"

I told them I would bring some ibuprofen or naproxen the next day. "It's true," Officer said, "I take tramadol and I don't even know I have pain—but then it comes back. That's why I came here—to try and find a cure. But now I'm sitting down, wasting time."

A man nearby was rubbing his foot, near a gaping sore. There were flies on it, and it didn't seem to be getting better. He said it hurt him so much he couldn't sleep. Liberian, perhaps thinking about our conversation on the chronicity of pain, said gently: "There are so, so many veins down in the foot, it takes time to heal. You need injections, plenty, like ten penicillin injections, then you rub the country medicine, then injection, then country medicine, then it will dryyyyyy up." It seemed to be his way of sympathizing with the man, offering his own prescription, a kind of titration of pharmakons and therapeutic genres, to help this man keep "cure" in sight.

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Liberian and Officer became increasingly frustrated at Bakarr. Sometimes the two patients rubbed the mud on themselves or smoked their bodies in leaves—they were ambivalent about Bakarr's therapies, and certainly seemed open to the idea that they were potent— but Bakarr had not given them direct clinical attention since he pulled out the threads. There was a constant line of new patients coming, and Bakarr was busy with them: doing the ritual in the hut

at which point the patients paid, a couple of hours of extracting threads, the *lalapinta* day. Other patients around Liberian and Officer who had come the prior weeks were also getting annoyed. They had paid so much they did not want to leave, but they had also plateaued in their improvements. They were afraid of incensing Bakarr in case he would attack them, so did not want to leave early. One *kres uman* had recently been brought back shrieking and babbling because, Bakarr told everyone, he had asked for a sheep as payment when the woman improved and the family hadn't provided it.

The naproxen tablets I had brought, Officer and Liberian said, were remarkable. For hours they felt normal again! Officer said he was also going to look up some yoga stretches on YouTube, and Liberian remembered some exercises from his days as a soccer player. They wanted to go home. The paralyzed man's little girl had come to visit, brought by her grandmother, to say hello. The two fell asleep in each other's arms, and then, when the girl had to go, they both started crying. This made everyone miss their children and families. Two days later, with the paralysis continuing to creep up his body, the man had taken the risk and just left.

Officer and Liberian were still interested in getting protective charms from Bakarr, even if they had given up on his treatments. "If you don't believe Bakarr's medicine, why do you want the charm?" I asked.

"I believe he knows about witch. So I believe he can do the charm. His problem is he can't say, 'I can't help with this, this is a natural illness.'"

I returned again to my central question: "You really don't want to know who did this to you?"

"That will cause chaos and grief for the rest of your life," Officer said as he had several times before. I thought of another line from that essay by Chris Abani, in which he quotes a

former child soldier talking about living with the knowledge of violence he and others had committed. “Listen,” he says. “It will always be hard to kill. If you cry like this every time, you’ll die of heartbreak. Sometimes it is enough to know it will be hard” (Abani 2009). Perhaps there was also a kind of ethics of care in this, and the Officer’s reticence to know his perpetrator.

Then Officer added mutter something else: “And maybe [what Bakarr would tell me] is not even true.”

*

One day, I went out with Bakarr and his assistants to collect leaves from the bush for medicine. In addition to the young man who helped with the thread extractions, a couple patients came along. These were people who had been living at the compound so long for their treatment they had essentially become apprentices.

We crammed onto a motorbike and were let off in a patch of savannah near an empty schoolhouse. I had thought we would walk into the forest some ways—Bakarr had trumped up the adventure of collecting leaves for some time—but I followed him as he climbed off the bike and immediately started pulling off leaves from the trees adjacent to the road. We stuffed the leaves in large rice sacks, and I asked him about the leaves we were picking. “For blood” he said reflexively, as he stood over one tree; “*Fɔ uman bɔn [to make woman pregnant]*,” he said of another; “*fɔ bad pipul dɛm, lɛ dɛm nɔ de biyɛn yu*. [For bad people, to kep them from coming after you]” I asked him what one leaf was called, and he responded, “*mossi*.” I asked if that was a Kuranko word, and he said “No, devil.”

As more assistants showed up, they too fanned out, and began picking leaves from what seemed every tree they came across. We slowly made our way up a hilly slope near a Fulani herder settlement. All the children knew Bakarr from these leaf-gathering expeditions, and were fascinated by my presence, playing peek-a-boo through the elephant grass. One leaf for *kres man* particularly excited Bakarr, and when we came across the head of the herding family Bakarr asked him if they knew of more. "Yes, yes, follow me," the Fula man immediately said, and showed Bakarr further up the hill. It was hard to tell if this was all a kind of metaphor, a tacit agreement that they would just take any old leaf and bring it back—after all, the leaves were all bunched together, and I wasn't sure what Bakarr would do with them when we returned. Or maybe there was an order to it all, Bakarr and his assistant knew the precise leaves to get, and the herder quickly recognized and had a sense of where the *kres man* leaf grew.

We returned to Bakarr's compound a couple hours later in the sweltering heat, and Officer and Liberian were hanging out in the shade. While Bakarr caught up with patients, the two men told me they were really ready to go home now and would be going in the next few days, and said they were quite certain that they just had muscle pain. Officer said that he realized he had been sitting so much more for his new administrative job, that must be causing the discomfort with his back.

Officer, Liberian and some women sitting near us who they had befriended talked about the crazy woman babbling all night as she was chained, shrieking and crying. Now she was silent, so it seemed Bakarr's Quranic readings had had an effect. The woman sitting with us said she had seen someone else once with a problem like the girl covered in the blisters. "Everything got rotten, the privates were all rotten. They went to many healers until they finally went to the *sokobana* society in Port Loko." There, a healer "sucked and sucked and sucked and sucked on

her cheek and pulled out a witchbone and then sucked and sucked and sucked and sucked on the private and pulled out a witchbone." So, the woman was saying, this is a treatable condition with the proper healing techniques. Still, her friend had been left with the "private allllll rotten."

As with the leaves, it was hard to ascertain her certainty: when she said it was the "same" condition, what did that mean? When Bakarr pointed out the leaf to the herder man, did the herder man really know where more of the "same" plants grew? Everything seemed at once so codified, but at the same time so uncertain, so improvised.

Later, Bakarr came over to sit with Officer and Liberian and two younger women who had come with their husbands and were undergoing the thread excision that day. Everyone was in good spirits. It gave me a new perspective, watching Officer and Liberian act so collegially with Bakarr when, in private, they whispered such bitterness about how he was a quack. Bakarr had such swagger and control over the whole complex, it seemed he had no sense of the discontent.

As I got up to go, Bakarr looked at me: "How you like me, so the devils like me! *Sababu, na smɔl sai i kin kɔmɔt!* [Good fortune comes from unlikely places!]"

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As Officer and Liberian became more skeptical and embittered at Bakarr and his medicine, I met other patients who were still in the joyous phase of treatment, feeling that they had finally reached a healer who could cure. I met soldiers, businessmen, teachers from all over the country.

One day, I sat down next to an old, middle-class man who worked as an insurance salesman. He told me all about the NGOs and businesses he had worked with over the years. But after a bike accident, he began to feel all sorts of pain in his body, knees, stomach, arms,

concentrated in the knees. At the hospital they just said: "Typhoid-ulcer." Soon he nearly couldn't walk, couldn't get up from a seated position. His movements were strange, floppy, like he did not have full control over his limbs. He had learned these problems were actually from witchcraft. I asked how he reconciled the bike accident with the witchcraft, and he looked startled trying to piece it together. He said maybe, like a trap, the *fangay* had caused the accident; or, during the accident he was distracted and someone shot him or put something in his body. "You know, this is a black juju country," he remarked passively, shrugging, as if just stating a fact of life these days, like *the contemporary economy of Kono District is highly dependent on diamond mining.* "We don't love ourselves, we don't love people developing, or development-oriented people, so if someone is leading an institution, or successful, maybe he is a family head, no sooner will he be shot." This was a matter of fact; he was just explaining his life and world.

I asked him and his friend, a soldier with a bulging vein in his leg that caused him pain, if they knew who had caused their problems. "Yes, they do say it was a black man, or a purple man, or a big man, 'I see this thing,'" the Insurance man said, imitating Bakarr or another herbalist. But, "I only want to see my health better." I asked about vengeance: "Bakarr is the boss, he can see and take it to the court."

"The court?"

"The witch court."

"Did Bakarr promise he would heal and then *prosecute* the person?"

"No," he said, but rather implied that he trusted Bakarr would pursue his "righteous work" beyond cure and to justice. Still, identifying the person was not his primary concern. Like Officer and Liberian, the insurance man just wanted cure, to return— after this pause in an

otherwise difficult life, a pause with new friends that he met in the process and this set of procedures— to the world.

*

I traveled to Freetown for a few days, and when I came back Officer and Liberian told me they had gone to someone else for care: a local bonesetter, or *gberiti.* They were discrete about telling me this, for Bakarr had made a threatening statement about knowing that people were getting care from other healers. One woman, who they thought Bakarr was alluding to, had brought her baby to Bakarr after a month-long admission to the hospital during which the baby was hooked up to oxygen for weeks on end. "They did an x-ray 4 times, and just said 'wait no more wait no more wait no more' over and over again," the woman had said. Bakarr said the baby had been attacked by witch and began his treatments, but the baby was still very sick. A friend had recommended another healer less concerned with witchcraft but who knew herbal medicine well. That herbalist had said the baby just had asthma and her own herbal remedy could help. The remedy dramatically improved the baby's health, but the mother was afraid to let Bakarr know, so thought she would keep indulging Bakarr and making him think that *he* was the one who was helping. "We can't know if it was the hospital, Bakarr or the new woman; the medicine might have fermented in the system," Liberian said.

This all made Officer and Liberian rather nervous about their trips to the *gberiti.* I had to admit I was surprised when they told me of this development. Before I had left for Freetown, they had seemed so emphatically invested in the explanation of muscle pain, which might be managed with naproxen and stretching. But evidently, the two still felt ambivalent about the

etiology and treatment, and had heard of a new possible outlet— for cure. This was not really a matter of *believing-in* a certain therapeutic modality or the efficacy of a way of understanding and treating their conditions, but a kind of open-minded swerving, again and again, as new prospects opened up.

I met them one evening in the *gbiriti's* house in town. It was a heavy, smoky, dark night in Koidu; lightning flashed in a distant thicket of clouds as I walked with David to the compound behind the city market. A group of people were crowded on the veranda of the house with an *okada* rider who had just broken his leg. He had already had the bone set and it was bandaged in thin gauze; an old car pulled up and a cluster of men carried him inside. When the *gbiriti* came back from the mosque where he had been praying, he called in Officer, and then Liberian. Inside the dusty and dimly lit compound, the man lay a plastic woven prayer mat on the ground and Officer lay down, as he had under Bakarr's razor.

First the *gbiriti* asked where the pain was, and Officer said mostly the leg. The *gbiriti* rubbed some waxy paste on Officer's leg and then began massaging up and down, up and down, and then tracing the tendons and ligaments. He then took a small calabash, whispered over it, and began a violent massage, pressing with all of his might down on Officer's back, making Officer arch his back and moan loudly. Over and over again he rubbed the calabash like he was kneading thick dough, and, whispering over some balms, rubbed those on the skin as well. He stretched Officer's legs back and forth, bending them at the knee and contorting him like he was doing a yoga bridge. Afterwards, many times, he asked Officer to stand up and looked at the way he was standing, before asking him to bend down and then lay down again for more forced stretching. It seemed like the *gbiriti* was tinkering with Officer's posture, a sort of osteopathic examination.

At the end, he quietly spoke to Officer—it was almost like he was muttering to himself, with long pauses, thinking, examining, muttering—and gave him the cream to rub. Some of this was explanations for what to do, but, I realized, he was also whispering incantations over the cream. I asked the *gbiriti* what he thought the problem was: "You know, there is a thing in the bone…the marrow." He said it had hardened, or the blood pooled, "there is a thing in the back…" He pointed towards the tail bone. "In America you have the surgery for it, but in Africa we do not have that capability, so we do this work, to flush out…"

He began the same process for Liberian, who said the pain had shifted to the veins in his groin. Both looked somewhat shell-shocked by the violent, physical process, but also visibly looser. They got on motorbikes to sneak back to Bakarr's compound.

The two felt like they were really improving with the *gberiti*. They had nowhere else to stay in Kono, so said they were thinking of Bakarr's compound like a hotel while they continued with the *gberiti*. Then, one day, Officer sent me a message: "We shall meet again by the grace of God. Because I will be leaving tomorrow for Freetown….I should have spent some time to observe this *gberiti* but my boss warned me to return or otherwise he will take action against me. So I have no option but to return to work." The pain was still there, he said, but he had taken too much time off in pursuit of cure.

I returned to Bakarr's compound a couple days later. I met Liberian hanging out with a new group of friends. He was covered again in Bakarr's leaves and mud. "Yes, I was feeling some—some pain," he said and pointed to his joints. He thought he'd give the leaves another go.

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As I was getting ready to leave Kono, I met another new patient. Binta was 23, but emaciated, with yellow eyes, and a bitter, pained look in her face. She said something was coming out of her stomach, and pointed to her loose abdominal skin matted in mud. “You see it coming out?” I said I didn’t see anything. She let out a bitter, sarcastic laugh: “You don’t see that?”

Binta wanted to show me papers from the hospital—she had been admitted, she said—and, as I suspected, it included all of the paperwork from the national HIV program. She was sheepish, we both knew what the yellow booklet meant, and I gave it back quickly. I asked if she had a community healthworker, a nurse who visited her at home as all HIV patients were supposed to have, but she seemed confused. Her treatment book noted that she had picked up her ARVs every month, and she and her husband, a police officer himself, said she took them every day. “We’ve been to the hospital so many times,” the husband said. “It costs so much. So let’s try this for some time, and see what this Bakarr man can do.”

I asked the woman if she was doing better since coming to Bakarr and learning that her sick was from bad people. “Small small,” she whispered.

I told them that I was no doctor, and they should do what they wanted, but that I had some friends who worked in the hospital and if they felt like going back I could arrange an easy visit. I said that there was no reason someone with this particular sick, at age 23, should look so “down.” I had heard that the HIV program had become more disorganized since Alliance for Health Justice had gotten bigger and staff had turned over. Especially after hearing the stories from Bakarr’s patients about the type of care they had received in the hospital, I wasn’t convinced that the nurses there who saw outpatients would assess the possibility of the woman’s treatment failure—that the virus could have mutated to resist the drugs she was on— or even

know how to switch the anti-retroviral pills. I was worried they might assume that the patient's problem was "non-compliance," yell at her and then kick her out again. So if I could help her see a doctor, to offer the kind of "technical know-who" (Whyte et al. 2013) that so often brokers care, maybe it would make a big difference.

I stayed in touch with the couple after I traveled to Freetown. Binta's husband kept saying she was improving "small small" at Bakarr's, let's try this, if she's not better we can go back. I called the manager of the HIV program who said he could help if she did return to the hospital.

A few days later, the husband left me a voicenote: they had gone back to the hospital. I assumed this meant that Binta's condition had worsened. Maybe, like everyone it seemed, they also had gotten fed up with Bakarr's neglect after a first few days of attention, and thought they would try the English side again.

I called the program manager, and asked if a doctor could see Binta—she clearly had fallen through the cracks before, and a physician who could better assess treatment failure might be able to help more. "We are on it. I am sure she will get good diagnosis," he responded.

A few days later, another message from the husband: "*My brother blood is problem*." I called again, the staff said they would look into it, of course as an HIV patient she would get a free transfusion.

I asked what ward Binta was in, and asked the doctor if he would check.

The husband began to send me voicenotes: "Anything for me? Anything for me? What happened?" By then I had traveled back to America.

A photograph: she was hooked up to an oxygen machine, eyes closed, skeletal.

An American HIV physician I knew was in town, I called him. He wanted to check on her, he was sure they had the medicines and equipment to save her life. He said that if she indeed had HIV there was no reason that someone this young should die. But the new Medical Director at the hospital said he did not want the American doctor to see patients without going through proper procedures first, this wasn't like before when any foreign clinician from a small global health NGO could just enter the wards.

I was getting worried—I had promised the family I'd help them if they went back to the hospital. I had so many colleagues working there, but all the new bureaucracies and global health institutions were just making it harder to figure out if any higher-cadre clinician even knew the woman was admitted. The husband texted me that she had ended up in the COVID-19 ward, which I had not known existed since they had not tested anyone in Kono for COVID-19 in months.

I sent one more note for to NGO staff—with modern medicine and HIV care, something *has* to be wrong if she looks like this, no? I phrased it like a question so that I wouldn't seem to be micromanaging, to make it more of a dynamic exchange but to prompt someone to look out for her. The HIV program manager said they had looked into it: the woman had had adherence issues in the past, had been treated for tuberculosis, then defaulted, was probably noncompliant. The doctors were on it.

I think I had a sense of where this was going. I heard nothing, no response, and sent another message to the husband: "How is she?" Silence.

Then: "Sir has die. This. Niegth."

Conclusion

Senegalese philosopher and economist Felwine Sarr writes that postcolonial Africa is under a period of "gestation," one that does not warrant "catastrophism or its inverted double: blissful optimism" (Sarr 2020, xi). This gestational project, he writes, "will consist of opening up other paths for living together and rearticulating the relations between different cultural, social, economic and political spheres, by creating a new *space of signification"* (11). The point is not to fall prey to the naïve confidences of Afrofuturisms that in the process efface the ongoing forms of misery, the structures and relations of power that emanate from far away and produce that misery, nor to further extract relations of care from engagements with the continent. Sarr does not use the word "proprioception," but in writing this dissertation I have often returned to his short text *Afrotopia,* for it is all about reimagining notions of space, place, where concepts about the continent emanate from, where they land, and what they do to real social lives and worlds there. The reformulation of those "*paths for living together,"* Sarr argues, ultimately must come from the African postcolony itself.

Now may in fact be something of the twilight of this well-worn era of global health in Kono. Donors are pivoting to paperwork over even vacuous community healthworker programs,[61] people in Kono have grown exhausted of the optimisms and promises that never materialize, and now ping pong and swerve between Bakarr and the hospital, conditions unresolved, trying to sustain a sense that they could get cure perhaps more than actually reaching

[61] The COVID-19 pandemic will likely further shift priorities within Sierra Leone towards health securitization rather than care.

it. In Sarr's rendering, we might think of this too as a process of gestation of the Sierra Leonean postcolony.

In a place like Kono that, as Sarr writes, is so "steeped in concepts, injunctions supposedly reflecting societal teleologies, a space saturated with sense," (xiii) from afar, so much structural violence, and in which death itself so often hinges on access or lack thereof to extraverted systems of care—like Binta's own tortuous and needless passing[62]—Sarr's insistence on there being *something* more essential and organic to drive the telos of development can seem blissfully, terribly optimistic. And yet, at times in Kono, one does get a brief glimpse into domains of histories, domesticities and affects held close and out of sight. In these memories and stories that people tell—and, perhaps, "live by" (Hurston 2008:3) – the ways in which contingencies are encountered and overcome can seem so different from those visible in people's engagements with and withdrawals from regimes of global health. I am always jolted, as if my map of this place, the fraught histories, the suffering, the poverty and violence, the living and dying, the theorizing of misfortune and even the ways that people seem to me to be making-do are, for a moment, beside the point and overwhelmed by vitality.

One blistering afternoon, just back from another difficult day at Bakarr's compound, I reclined in a chair on David's veranda. The wind blew the elephant grass softly, carrying the smell of moist, recently turned soil. Some men back from the mines for the day listened nearby to a muffled reggae track, sachets of gin hanging from their mouths. Only steps away from Bakarr's place, where everyone knew there were so many patients in so much pain, there was true quiet and calm.

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[62] Donated ARVS, foreign NGOs, foreign healthworkers, etc.

Fengai, an old man who David had hired to seed some beans on his farm, came walking back from the field. “This man has interest in the stories,” David said to Fengai, nodding at me while he rolled a joint. “You know, what the old *pas* used to tell when they were setting traps.”

Fengai grinned:

LONG TIME AGO SOME BUTTERFLIES DID COME
They were all white
So they came from up and went towards the sea
They were all white
At that time, in the morning, it was 8 to 9
So there was complete darkness.
I was in Gbendema doing gold mining when that happened
All were afraid and went back to town because they had never seen something like that!
And they were surprised—we never knew what it was!
What happened after that? They said, well, the war is coming.
And that war, it never happened, it never came.
It never came.
It didn't affect Sierra Leone.
So the people that knew what was what, they knew that this war was coming.
They protected Sierra Leone with a big net. For the war not to come.
So they fought with their leaves…to avert that.
They tied some [medicine]…and put it on the river.
So the thing traveled by the waterways until it went into the sea in Freetown.
[People] were just thinking it was like ordinary leaf.
But there were people in the leaf.
They were well protected by their juju.
So that happened and I was a witness to it, so it's not like a story, being made up.

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