Quarantine and Its Malcontents
How Liberians Responded to the Ebola Epidemic Containment Measures

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ABSTRACT: This article examines how populations affected by the Ebola epidemic in Liberia reacted to the implementation of mandatory, state-imposed quarantine as a way of curtailing transmission. The ethnography, based on in-depth fieldwork in both urban and rural areas, shows how mandatory quarantine caused severe social consequences for both people's perceptions of epidemic control and their health-seeking behaviours. The authoritarian imposition of this public-health measure soon became a driver of social fear that contributed to the divide between institutions and population, jeopardising the control of transmission. Its implementation overshadowed more acceptable local quarantine measures that communities were organising to protect themselves from transmission. The analysis argues that quarantine in Liberia was counterproductive and suggests alternatives to epidemic control rooted in social acceptance and local practices.

KEYWORDS: Ebola, Liberia, outbreak control, public health, quarantine, social fear

It was a misty Wednesday morning in late August 2014 when the residents of West Point, Monrovia, woke up trapped inside their neighbourhood, a piece of land surrounded on all sides by water and connected to the rest of the city by a bridge. Police came in numbers to enforce a cordon sanitaire across the entire area to contain what was considered to be a potentially explosive area for the spread of the deadly Ebola Virus Disease (EVD) that had at this point already killed 1,200 people in three countries across West Africa. The armed wings of the Liberian Government were disguised behind protective anti-riot equipment, their faces and bodies protected from the stones thrown by locals protesting against what they perceived to be abuse. Wearing their own version of PPE, the officers with teargas were, for the population of West Point, representative of their Government's response to a high-level public-health concern. This harsh, violent response to controlling the transmission of Ebola was officially justified by reasoning that West Point is a slum area (Snyder et al. 2014), whose residents were accused of being non-compliant to requests to report suspected cases of Ebola and dead bodies. High ranks of the Liberian Government blamed 'citizenry of Liberia for continued denials, cultural burying practices, disregard for the advice of health workers and disrespect for the warnings by the Government' and thus justified an armed intervention. The Government task force saw the forced quarantine of an entire neighbourhood such as this one as being in the interests of the wider public.

Unfortunately, this event resulted in the death of the young Shakie Kamara, a fifteen-year-old boy shot in his legs by a police officer during the protests against the mandatory quarantine, and many others being wounded. West Point's events paved the road for forced quarantine as a containment measure of EVD transmission to spread across Liberia. It was a highly contested and debated public-health strategy.
amongst all the stakeholders involved in this dramatic year of the largest Ebola outbreak in human history.

This article offers an ethnographic account and some reflections on quarantine and the events surrounding its implementation: it attempts to grasp the response of Liberian citizens to such imposed containment, their perceptions towards state-enforced public-health measures and community-level alternatives. The research on which this study is based forms part of my work as an anthropologist for the emergency response of the humanitarian aid organisation Médecins Sans Frontières (MSF), for which I conducted research and provided reports on different aspects of Liberian social dynamics within the epidemic. Here, I focus specifically on quarantine, drawing my anthropological analysis from the point of view of local communities, rather than from the perspective of the medical organisation. I believe that organisations such as MSF and others can greatly benefit from understanding the active role played by communities during the epidemic, both as a way of evaluating their intervention and in terms of developing strategies if such a crisis happens again in the future. Moreover, the aim of this article is to contribute to a critique of public-health measures and policies framed through top-down interventions. For these purposes, after the ethnography and analysis, a final section with practical recommendations for both organisations and policymakers is proposed along with considerations for the role of applied anthropologists in epidemic situations such as this one.

Indeed, the following ethnography views people's actions and perceptions beyond the classic paradigm of considering them as beneficiaries passively waiting for help or charity. When I met with a group of young men and women in West Point in January 2015, their memories of August 2014's quarantine remained vivid. They were not emotional when they recalled the events of that period but instead questioned the relationship between the use of violence on people and the containment of an outbreak. ‘We didn’t understand the logic’, said a 21-year-old man who witnessed the riots: ‘instead of giving us ambulances and clinics, they pushed us in. They wanted to exterminate us’. Framed as vectors of the disease, with their practices blamed and their freedom restricted, West Point’s population shared – with many other Liberians – a bitter sense of being responsible for the transmission of the virus and being incapable of protecting themselves. Such blame, and the social fear that occurred, created a divide between the Government-led task force and its constituencies.

The Liberian Ministry of Health (MoH) emergency regulations believed that the isolation of persons suspected of exposure was an efficient strategy for controlling EVD transmission. Such isolation turned into coercive forms of quarantine, where the contacts of positive cases identified by the relatives of patients at Ebola Management Centres (EMCs) were supposed to restrict their movements during a 21-day period of incubation and be checked by health personnel for any development of symptoms.

As the following ethnography will show, this measure not only, in the long term, ran the risk of being an ineffective intervention that operated like ‘driving a carpet tack with a sledgehammer’ (Drazen et al. 2014 : 2029), but it also became a driver of fear among the population and a device to exercise power. As such, this applied anthropological research argues that forced quarantine was counterproductive and inefficient in controlling transmission, since it did not facilitate mutual trust between the Government and its constituencies and instead shaped stigmatisation and inequalities. The following study focuses on how Liberians perceived state-enforced quarantine and how they found alternative ways to isolate the contacts of EVD-positive cases. The ethnographic accounts offer a different image of Liberian communities from those portrayed in the mass media by their negative behaviours, such as hiding bodies or sick persons and not seeking health-care services. Indeed, this analysis also indirectly provides an explanation of such events, framing them within the general power relationship produced by a coercive public-health approach led by state-related actors.

The study is based on four months of fieldwork in Liberia conducted during two different periods of the epidemic: September to November 2014 and January to March 2015. The first period of fieldwork took place during the emergency phase of the epidemic when there were a high number of cases, while the second visit took place during a much more stable period. As a member of MSF’s emergency response team, I was in charge of conducting anthropological research which could drive medical operations and provide an in-depth understanding of local social dynamics.

As discussed in the introduction to this special issue, classic anthropological methods – such as participant observation – became risky activities since they involve close contact with people with an unknown health status. However, through adopting safety procedures and ensuring the ‘no touch policy’ was followed, I was able to carry out in-depth interviews and focus groups with different groups of people, from local political and religious leaders to commu-
nity members. Narratives were collected, in addition to an analysis of the different clusters or neighbourhoods in which EVD was present, in order to understand different patterns of transmission. Although in-depth participant observation was not conducted because of security restrictions, I visited quarantined houses and witnessed other social events on an almost daily basis. Two local Liberian research assistants helped by creating a network of informants and assisting with translation during fieldwork. The fieldwork was carried out in two counties, Montserrado and Grand Cape Mount. The first is a peri-urban environment where the municipality of Monrovia is located, and the second is a much more rural area, characterised by small- to medium-sized villages surrounded by palm plantations and mines.

Quarantine in Monrovia: The Epidemic of Fear

The social impact of state-enforced quarantine in Montserrado County, and Monrovia in particular, derives from the harsh implementation that fuelled social fear, the limited efforts from implementing agencies (MoH and partners) to involve the population and a poor understanding of community dynamics. As I will show throughout this article, the terminology and phrasing around the concept of ‘quarantine’ took on different and, in many cases, vague meanings during the EVD outbreak. Organisations and state agencies already had differing definitions and ways of practically implementing quarantine; at the same time the public use and circulation of the word contributed to frame the control of the epidemic as a form of fight against an enemy – a war – where quarantine was a form of punishment or jail.

The words used by West Point’s residents mirror the general dismay present in all research participants’ narratives: people described themselves as feeling like ‘prisoners in their own house’, ‘culprits’ or ‘scapegoats’. The word ‘quarantine’ was hailed loudly in the national and international media, and its call became a type of litany with magical efficacy. It seemed from reading international media reports that putting people into quarantine was the only means of cutting the transmission of the virus, yet Montserrat’s citizens were not witnessing a decrease in the number of Ebola cases: on the contrary, cases continued to be identified despite the harsh measures taken, and the perception of being quarantined as a means of punishment fed people’s already growing fears. Social fear was linked to the harsh awareness messages used to inform the population about the epidemic that left people believing there was no hope for a resolution of the crisis. Moreover, the setup of the emergency response was extremely weak; people reported delays in the collection of dead bodies from their homes or personnel easily bribed to allow a private burial to take place; ambulances not appearing after being called and an inefficient emergency hotline. In addition, there were various visible contradictions, such as the closing of public hospitals when private clinics continued to operate and the banning of ‘traditional’ funerals, when private funeral homes continued to embalm bodies. In other words, if social fear in the so-called Western World was seriously driven by social behaviours and public opinion, in Liberia it was not considered a structural component influencing the transmission of the virus.

The term ‘quarantine’ was used indifferently (and without being fully explained to people) to describe the centralised, state-enforced, coercive isolation of asymptomatic contacts of positive Ebola cases for a 21-day incubation period and the home isolation practised by families of a sick person waiting for an ambulance. The Centers for Disease Control and Prevention’s (CDC) definition distinguishes between ‘isolation’ as the separation of sick people and ‘quarantine’ as the separation and restriction of movements of those potentially exposed to the contagious disease, to monitor their status. Current debates in the fields of public health, ethics and law point out that beyond the public-health definition, quarantine has limited efficiency as a containment measure, and can have delicate ethical and human rights consequences (Di Giovanni et al. 2004; Gostin et al. 2003; Markovits 2005; Rothstein 2015a, 2015b).

In Liberia, the definitions and the uses of quarantine were very confused and ill-perceived by citizens and local leaders. Information on quarantine was poorly explained and awareness campaigns concentrated on ‘behaviour-change’ practices linked to phenomena that only had a limited connection to the transmission of the virus, such as eating bush meat or participating in traditional funerals. If the latter, especially traditional burials, were in some cases linked to transmission early on in the outbreak, quantitative analysis of the clusters of the spread of EVD show instead how private clinics, health-care facilities, delays in seeking care because of fear and other forms of social resistance played a major role in transmission, yet were little tackled by the emergency response. The Government’s Ebola task force failed to conceive alternative, less coercive measures and language which could have decreased social fear.
and created an environment of collaboration to control transmission.9

Within this confused environment, state-enforced ‘quarantine’ was meant as a way to monitor and control the symptomatology of contacts of positive Ebola cases throughout the 21-day incubation period, as a means of protecting the wider public from possible sources of infection. The MoH was in charge of monitoring the health status of quarantined individuals, and other agencies were tasked with supporting those who had been quarantined with basic livelihoods. Ethnographic data from field visits and interviews reveal a weak implementation of the forced separation of contacts: action was often taken by police forces, in anti-riot fatigues, without any prior explanation or advance warning. The contacts, whose movements were restricted for 21 days, rarely received a daily follow-up visit from MoH health personnel to monitor their status or measure their temperature and symptoms. Another example of the growing sense of abandonment due to the weaknesses of the system was that aid agencies connected to the Government’s task forces were reported to distribute food supplies was that aid agencies connected to the Government’s abandonment due to the weaknesses of the system produced ‘grey zones’ where mistrust towards the State brought transmission control to a grassroots level that in some ways echoed the aims of the official quarantine but was more sustainable, acceptable and participatory.

Montserrado County and Monrovia saw many self-organised community responses. Due to the wide demographic and sociological diversity of the environment, precise patterns are not easy to locate, but some commonalities can be drawn between them. Local community leaders organised task forces composed of young people who were then trained and given basic information on how to recognise the disease.11 The movement of non-residents was banned, and the same task force was also in charge of reporting and enquiring about new people arriving in the neighbourhood. In the event of individuals being identified as the contact of a positive person, they were immediately requested to stay at home, and local leaders and task forces set up regular visits to bring food, water and other items, whilst simultaneously monitoring their health status. The leaders, often with representatives of churches or mosques, visited the neighbours’ houses to explain the logic of this local quarantine. In some cases, people under quarantine were allowed to make movements to get food, or follow-up their jobs and small businesses after a morning measurement of their temperature if they agreed to communicate with the leader or a representative of the local task force. At the end of the 21 days, the leader would organise a ceremony for those who had been quarantined, who were by then free of any controls or restrictions. The feast, called a ‘graduation ceremony’, involved the participation of the wider community with speeches, prayers and dances. In the event of a symptomatic episode, the leader was responsible for calling an ambulance, and the task force was ready to transport the person safely to the treatment centre. Local isolation was certainly not perfect, and local leaders and task forces needed a lot of managerial, financial and material support. Nevertheless, within the grey zones left out of the centralised emergency response, they were able to self-organise a form of transmission control in their communities and to respond, to a fair extent, to the needs of their community.

Illustrative of this is the case of Mount Barclay, a community a few kilometres from Monrovia, where the local leader refused to label the isolation of individual contacts of Ebola-positive patients by local community members as ‘quarantine’:

I can’t understand why everyone’s using quarantine! When Mr B. [the positive case] died, all community participated to the mourning, he was part of us. We don’t see his relatives as our enemies, they’re our fellows. Quarantine cannot work here, it drowned people in fear and economic hardship. We don’t ban movements, they are free to go and get food.
Instead, the community’s task force organised a daily follow-up to monitor symptoms, which allowed their fellow members to circulate freely after their check-up. Stigmatisation was very low, and the community was informed and allowed to maintain relationships with the people under surveillance.  

Quarantine in Rural Areas: Solidarity and Inequality

The forced quarantine of contacts was in operation across Liberia, including in remote areas. Even if its practical enforcement was similar to that in Monrovia, the response of the population in the villages could be summarised by two unique social dynamics: solidarity, as communities refusing coercive measures activated their social networks to self-manage the individual contact, and inequality, as quarantine was a factor of discrimination and stigmatisation that echoed pre-existing social fractures. Grand Cape Mount County, near Sierra Leone’s border, was severely hit by the epidemic: authorities closed markets, patrolled the main roads with special police blocks and adopted widespread control measures. People in the districts called the Ebola virus *kombua*, a Mende expression which translates to mean ‘the rotten tree’. It is said that Ebola acted as an invisible mould that could turn a living being rotten from the inside whilst simultaneously threatening to affect others. The idea does not seem to be connected to any spiritual beliefs but to be a purely empirical concept springing from the observation of the symptomatic reactions of ill people. In this sense, communities believed that the idea of isolation was crucial to curtail the transmission, and the preparation of special rooms in the house where the sick person waited for the doctor was an accepted idea, as was the fact that whoever was in contact with the sick person should behave in such a way as to protect the whole community.  

Indeed, another metaphor used to describe the experience of Ebola is ‘playing the lottery’: it is said that touching an infected person can bring either life or death, as a win-lose game. Isolation and the aforementioned ‘no-touch policy’ was a known behaviour within the population. Different from a coercive quarantine and a total ban on movements, villagers perceived the care of the sick as being as important as public well-being. In most cases, the whole community visited and interacted with the family that contained a sick person and supported them with food and other items. Augustine Village is a settlement of one hundred people, deep in the forest a few kilometres from Bangoma, in the borderland Tewor District of Liberia. An elderly woman in the village was mother to a young woman who had died of Ebola ten days earlier. She had been taking care of her daughter and her two children, so the authorities put all of them under quarantine in the same house. The old woman was helped by community members who provided her with food, water and firewood. From the beginning of her quarantine period, she only received two visits from the MoH staff member who was in charge of checking her temperature, and received no support at all from other NGOs in terms of food. During her quarantine, her son-in-law came to visit and attempted to take the children away with him. The man was supposed to be in quarantine himself, but he was reported to have paid a bribe in order to be released. He came during the night, and some young men near the house of the woman woke up and noticed that something was wrong. They went together to find the local chief and chased the son-in-law away, keeping the children in the house. This kind of solidarity was not uncommon in the small, geographically isolated community as there was a continuous risk of exploitation from illegal miners. In this case, Ebola did not find them unprepared: they had tools to stay protected. As Barry Hewlett has shown for the communities in Uganda (Hewlett and Hewlett 2008: 45), in Augustine Village existing security protocols were adapted to the new threat.

The cases in Grand Cape Mount County’s villages are also illustrative of how forced quarantine contributed to increase levels of stigmatisation, tore apart communities and became tangled up within existing inequalities. Due to the compulsory and authoritarian nature of the mandatory isolation imposed by state-related agencies, it became a tool of political division. In this sense, it drifted away from the supposedly neutral control of transmission and became a device of social division.  

The example of the Fula community in the districts of the County is useful here, as the Fula were targeted by the Vai and Mende majorities for spreading the virus, as local stereotypes categorised them as nomads and traders, with a thick web of contacts across West Africa. The ethnic tension between Fulas and other ethnic groups in the region is long-standing, and although most Fulas are Liberian citizens and often intermarried, they are still not believed to belong to the territory. In the village of Tieni, a family of whom some were Fula was hit by the virus. As a result, health authorities quarantined most of
the members of the extended family, including some who were not contacts of the positive case. The District health coordinator of the Ebola operation confessed that he had followed the ethnic line to include people not in the contacts’ list, identifying the Fula as a ‘risk population’ because of their alleged mobility. During interviews, Fula explained that they perceived an increased tension and pressure upon them after quarantine was implemented. This was an environment that produced separation, and made the supply of food and firewood very difficult for those in quarantine. The interplay between pre-existing levels of stigmatisation and the new ones produced by the containment measures led to a laceration of the social material which in turn became detrimental to the control of the virus.

Quarantine and Its Malcontents: The Political Economy of Health

Since the time of its first major application during the plague of the fourteenth century, quarantine has been a controversial infection-control measure (McLean 2014); its use entails a period of total suspension of social, religious, economic and ordinary political activities. Philosopher Giorgio Agamben’s (2003) definition of a ‘state of exception’ seems to grasp at once all implications of such severe public-health measure: as for an extraordinary state of emergency, whose causes and consequences remain unexplored or unexpressed to the general population, the political power subordinates the political life to a paradigm of government for which normal rights are suspended. Quarantine in Liberia assumed some features of Agamben’s state of exception: people’s movements were restricted, their rights were suspended and normal, daily activities became subjected to a process of accusation. On the other hand, the Government and international agencies were imposing a measure through ways – like the use of armed forces or deprivation of liberty – that would be hard to conceive in the Western World without raising condemnation from public opinion.

This showed how the global health response dangerously applies double standards to health needs which in turn threaten to reproduce global inequalities (Farmer 2001). Global inequalities can also be seen in the limited possibilities Liberians had to access national and international debates about their own health. If the single case of a quarantined nurse returning from West Africa to the United States raised a huge debate, a little attention was given to the hundreds of people quarantined in Liberia, Sierra Leone and Guinea, whose protests to governments and international aid agencies were considered ‘unexplainable’. In light of the ethnography this article has presented, West African citizens’ protests can be better interpreted by viewing part of these rebellions as forms of resistance towards an imposed, as well as ineffective, power. Resistance, for this analysis, is not only confined within the classic boundaries of counter-violence (as in the case of West Point’s riots) but forms part of the counter-narratives of Liberians opposed to the international and national agencies. Moreover, resistance was also a form of transmission control operated from the bottom up that, despite its weaknesses, found more compliance and, in the long run, became an interesting pattern of public health.

Resistance has historical roots. Quarantine not only fed fears and inequalities (Allen et al. 2015), it became another tile in the Liberian mosaic of civil wars and people’s disempowerment. Indeed, Ebola came soon after a short period of stability following a state of war that lasted decades. For months, the outbreak swept away people’s hopes of leaving behind the historical trajectory of a country that considered them subjugated. The local interpretations of the outbreak – that recalled war or international conspiracy – were attempts to frame the disease and the Government’s coercive behaviour and make it understandable. Quarantine and other coercive measures to curtail the epidemic can be interpreted through the theoretical framework of the anthropologist James Ferguson as examples of technical solutions to a problem, presented as ‘anti-politics’ (1990). However, the local resistance to such solutions re-politicise them and bring them into the realm of social dynamics. The lesson learnt is that, whatever solution an NGO might find to tackle a problem, this will never be objectively neutral but always politicised. In this sense, any solution for a humanitarian problem, even if apparently technical, will always be a part of historical and political dynamics: as discussed in the introduction to this collection of articles, this is one of the reasons anthropologists were involved in the outbreak response.

Consequently, it makes sense here to interpret the communities’ response through the category of resistance. West Point’s riots, as well as Augustine Village’s solidarity, resisted a state-imposed model of public health and model of care that did not consider the publics it intended to protect. Beyond the wordplay, this ethnography raises questions on which publics – communities, people, citizens – public-health measures are addressing, even in times of emergen-
cies. Quarantine showed its malcontents again when put to the test in the largest Ebola outbreak in human history, disclosing the need to search for new forms of public-health measures together with an analysis of the social trajectory of infectious diseases.

**How-to? The Alternatives to Quarantine**

*Surveillance and Community-based Contact Tracers*

Through an in-depth context ethnography of rural Sierra Leone hit by Ebola disease, the anthropologist Paul Richards and his team present, in a 2015 article, the social ties between marriages, funerals and land tenure practices characterising the social features of Fogbo communities in Moyamba District. The research – another example of applied anthropology during the Ebola outbreak – shows how patterns of contact tracing and reactions to the epidemic are deeply rooted in the interconnection of these social events. An in-depth knowledge of sociocultural dimensions is therefore considered essential to the successful surveillance of the community. In line with other examples from previous outbreaks described by Barry Hewlett and the cases presented in this article, Richard’s work demonstrates that applied anthropology is not only possible in the case of outbreaks, but is also required for better case control.

In my view, applied anthropology disentangles health agencies from the idea that a top-down approach is the only possible solution in the case of outbreaks. Quarantine, as a coercive device, can be replaced by better case surveillance based on concrete social dynamics that can be organised along with locally based health promotion through community health workers and leaders. The latter should not only be easily recognised political figures but religious, spiritual and informal opinion leaders who have a role to play as well. A socially rooted surveillance and contact tracing strategy should involve collaboration between epidemiologists, anthropologists and community members as a team of peers sharing and conducting research. An ideal framework would be the following:

1. In-depth research on social dynamics, cultural features, hierarchies and drivers of fear surrounding an outbreak;
2. Identification of community health workers, based on sociological and epidemiological data (e.g. number of people in the village, ethnic composition, religion, probability of disease transmission);
3. The subdivision of areas of intervention;
4. Framing teams (divided by geographical area) composed of a triangulation of community workers, leaders and health-agency members (health promoters). The team understands the realities on the ground, is responsible for managing contacts and is the referent for external help (ambulances, burial teams). In the event of sensitive activities such as the removal of dead bodies, the team can convene a group of influential people to reassure the relatives or explain the ongoing process;
5. Utilising the team as a living source of information on the movement of people to assist with the coherent update of contact tracing files for epidemiological purposes. Isolation of contacts is prepared and explained during this process. Once it occurs, the team can manage local forms of support and link up with the contact tracers of health agencies to monitor symptomatic events.

One of the limits of such a system might be seen to be the large numbers of people involved, who would need to be supervised and managed. But, as this study attempts to show, actors need to move from the idea that ‘locals’ need to be managed, to one which involves them in creating a common ground for action. Second, resources, including financial ones, are traditionally destined to ‘community-based’ approaches that eventually become simple and endless mass-awareness campaigns (including billboards, flyers, megaphones) whose impact is difficult to measure. The same resources can be directed to the proposed approach, investing as well in a structured coordination of health agencies (both governmental and non-governmental) involved, donors and policy makers.15

*Local Forms of Isolation*

Although it might sound paradoxical, the experiences of the people I interviewed in Liberia show how, during the outbreak, a re-created form of ‘contact’ – meaning, keeping social relations with the sick or the contact as normal as possible – was the best strategy for lowering the risk of transmission. The cases of Mount Barclay and Augustine Village demonstrate that the isolation of a contact cannot be socially hermetic: the feeling of being supported helps both those under isolation and the community as a whole since it provides a sense of mutual trust and sustains a grassroots initiative based on local dynamics and patterns of epidemic explanations. The communities,
holding the ownership of the isolation of the members, felt involved in the dynamic and not simply subjugated by external actors perceived as dominant and unintelligible (i.e. opposing awareness messages). This reduced the ‘sense of being in a war’ or, in other words, the dramatic fear that pushed down every attempt to cut the transmission of Ebola. Other stakeholders involved in outbreak control could set their operations alongside local knowledge and practices, instead of importing new ones. Support with food, items and primary health care is as important as creating an environment of dialogue between all actors involved, where community members both under isolation and not can have access to clear information and data on the epidemic trends. Scheduled meetings or forums for awareness at neighbourhood or village levels might have a greater impact than centralised, closed-door, high-level meetings where the citizens receive partial echoes of information through the mass media.

**Politise or De-politicise Quarantine? Involve Communities in the Debate**

Medical and public-health studies on quarantine as a form of infection control during outbreaks are characterised by a biomedical rationale which justifies this form of isolation by the principle of the protection of the public interest over the individual one. Legal, ethical, human rights and more innovative public-health approaches (Rothstein 2015b) instead see quarantine as a case-by-case option that should be considered if the civil rights are assured, financial compensation for job losses is provided and a transparent process of awareness and information-sharing is put in place.

This article contributes to the idea of bringing a bottom-up approach that sees the concrete actions of the people as the main object for analysis. According to this perspective, what this research observed is that within all scientific debates and forums that have quarantine as a topic, those who were subjected to this form of isolation were not involved as speakers or stakeholders. Communities, citizens or populations are perceived both by scholars and agencies as homogeneous and rigidly defined entities that must be controlled for the sake of their own lives. Such an approach recalls Michel Foucault’s idea of ‘biopolitics’, according to which power is exerted through mechanisms of discipline and control over the health of a population, ill-defined as a ‘mass’. Quarantine, in this sense, appears to be a device of political control and power. Regardless of all attempts of studies and agencies’ forums to de-politicise quarantine as a mere biomedical public-health tool, the Ebola epidemic and the experiences described in this article show that it is a profoundly political practice, which features along power lines, hierarchies and unequal distribution of decisional power. Hence, if quarantine is to be considered an option in an epidemic, communities must be recognised as being involved in the process of decision-making, and their agency and contribution to providing options for epidemic control acknowledged.

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**Notes**

1. Personal protective equipment (PPE) is the yellow suit worn by health-care workers dealing with infectious patients. If PPE became a global symbol of the fight against the virus during the recent Ebola outbreak, locally it was perceived as a barrier, or a sign of the evil.
5. The incubation period refers to the time between infection with the virus to onset of the symptoms. The World Health Organization sets the interval from 2 to 21 days (see http://www.who.int/mediacentre/factsheets/fs103/en/, accessed 15 November 2015). A person is only considered infectious if symptoms start (see http://www.cdc.gov/vhf/ebola/transmission/qas.html, accessed 15 November 2015).
6. In Europe and especially in North America, the fear of a spread of EVD occupied public debates for months, with a plethora of experts discussing how and why Americans should not be scared. See for example: http://blogs.scientificamerican.com/crosscheck/ebola-8220-fear-mongering-8221-criticized-by-medical-anthropologist/ (accessed 16 November 2015). Despite the outbreak being confined within three African countries, in 2014 the media and scientific community discussed it as a worldwide epidemic that impacted upon global security mechanisms (e.g. airport controls), modified global trades and politicised national issues.


8. See the St. Paul Bridge’s cluster reconstructed by the Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6418a5.htm (accessed 4 November 2015).


11. For ‘local leaders’ I mean political (institutionally recognised) figures (e.g. chairpersons), both religious and informal, although influential, ones. The concept of (local) leadership used in this article is wide, and indeed includes the complexities of political powers on the ground. Indeed, leaders of the secret societies (of which Poro and Sande are the most known) are included in this definition.

12. More details on Mount Barclay’s case and others can be found in Pellecchia et al. (2015).

13. Similar episodes of self-management of the infectious disease in the villages are reported in the anthropological literature on Ebola, as Barry Hewlett shows in Uganda and Congo (Hewlett and Hewlett 2008).


15. That is also a point, generally speaking, for public-health investments as policies of states and international organisations. As Paul Farmer (2001) points out, cost-effectiveness paradigms cannot be the sole dimension to consider in a public-health intervention. And, even when considered, how and where to direct funds is a matter of political economy.

References


