



**FEVERS, FEUDS, AND DIAMONDS:
EBOLA AND THE RAVAGES OF HISTORY**
BY PAUL FARMER

Partners In Health Co-founder and Chief Strategist Dr. Paul Farmer visits the Maforki Ebola Treatment Unit in Port Loko, Sierra Leone in 2015. Farmer speaks with a members of the Cuban clinical team partnering with PIH clinicians in staffing the Maforki ETU. Photo by Rebecca E. Rollins / PIH

**An excerpt from Paul Farmer's new book
*Fevers, Feuds, and Diamonds:
Ebola and the Ravages of History***

This year, Partners In Health Co-founder and Chief Strategist Dr. Paul Farmer has authored a compelling narrative on the 2014 Ebola outbreak in West Africa. PIH responded to the devastating virus early in the outbreak, by supporting and accompanying local health organizations and governments. And since

that Ebola outbreak subsided, PIH has continued to support strengthening health systems and provide lifesaving health care in Sierra Leone and Liberia.

In his new book, Paul shares firsthand accounts of his experience during the devastating Ebola outbreak, stories of victims, the implications of systemic injustices on health care, and the lifesaving importance of strong health systems. **We are very excited to share this excerpt with you.**

The Twenty-Fifth Epidemic?

This is the first time the disease has been detected in West Africa, and the outbreak has now spread to the American and European continents.

— World Health Organization, October 24, 2014

Serologic results provide evidence that ebolaviruses are circulating and infecting humans in West Africa. This extends the ebolavirus geographic region to Sierra Leone and the surrounding region.

— Dr. Humarr Khan and colleagues, in reference to blood samples collected in eastern Sierra Leone over the decade prior to 2014

The regions usually affected by the Ebola virus—in or near the receding forests of central and eastern Africa—have long been the theater of explosive if uncharted epidemics. When these plagues kill, as they're apt to do in a medical desert, surviving family don't receive any official report of cause of death. No labs or health systems have tracked the disease while treating it; nobody can say for sure what the culprit pathogens are. To echo Albert Camus, nobody knows what's come crashing down on them. Survivors and their families come up with their own explanations. So do epidemiologists, medical journalists, and public-health authorities of every stripe.

West Africa's Ebola outbreak, the largest in recorded history, is widely held by expert opinion to have its origins in the eastern reaches of Guinea, Liberia, and Sierra Leone, which converge in a bit of turf known as the Kissi Triangle. For centuries this "trizone" region—in which the virus, we're assured repeatedly, was unknown until 2013—was largely covered by a mosaic of forest and savannah, tended by a large and mobile population of farmers, traders, and hunters of diverse origins. (Guineans often call them forestiers.) In recent decades, commercial logging, small-scale charcoal production, mining, and war have greatly reduced the forest and its wildlife. From this disrupted real estate, Ebola snaked its tendrils into several other nations. But it was in Guinea, Liberia, and Sierra Leone, and really only there, that the epidemic blanketed the land.

Why? All documented Ebola outbreaks—the World Health Organization (WHO) pronounced this one the world's twenty-fifth—have been registered in settings of profound poverty. By most criteria, that's an apt description of what one finds in Guinea, Liberia, and Sierra Leone. But in terms of gross domestic product per capita, these three countries were growing faster than the United States or Europe throughout the decade prior to the outbreak. Measured only by this tired calculus, Sierra Leone boasted the world's highest rate of economic growth in 2013.

The engines of this specious boom remain the extractive industries—logging, along with the quest for oil, minerals, precious metals, diamonds, and rubber latex. But profits from these industries rarely remained in the vicinity, and they were almost never invested in public goods, such as robust health systems able to contain epidemics—or to flatten their curves and surges—while caring for the afflicted. Maybe in Norway, but not in West Africa: For all their natural wealth, Guinea, Liberia, and Sierra Leone rank among the most medically impoverished nations on the face of the earth; for all their rainfall, their citizens are stranded in the medical desert. In this desert, a diagnosis—and answers to the who-when-why-how questions—is more likely to come from a diviner or other traditional healer than from a laboratory, or is produced by authorities well after the fact and on a basis other than firsthand observations. This raises a corollary question. When an epidemic occurs in a public-health desert, who decides when and where it begins or ends?

To understand the how and the why of the West African Ebola epidemic, you have to turn first to the specifics of who, when, and where. Since Ebola is a zoonosis, a disease caused by a pathogen able to leap from its natural hosts to humans, the people posing these questions tend to search for an outbreak's first human victims. Epidemiologists, health authorities, and journalists look for "Patient Zero" and seek to trace subsequent paths of spread. But Ebola origin stories can rarely be confirmed, since most stricken by Ebola in the clinical desert die. Blood samples aren't often collected prior to death, nor are postmortem studies performed.

Here, with ready acknowledgment of uncertainty, is the dominant origin story of the Ebola epidemic believed to have begun at the close of 2013 in southeastern Guinea.

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800 Boylston Street, Suite 300,
Boston, MA 02199-8190
857-880-5100 • www.pih.org



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