When the Fever Breaks

Government measures have proved inadequate, but communities in Liberia and Sierra Leone are coming up with ways to battle the Ebola virus.

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An isolation ward in a former classroom in Monrovia. The World Health Organization has documented eight thousand deaths in Liberia and neighboring countries, and the actual toll is almost certainly much higher. Credit Photograph by John Moore / Getty

Robertsport, the capital of Grand Cape Mount County, in northern Liberia, lies at the remote end of a long peninsula, between Lake Piso and the sea. Even during the dry season, the road that leads to it is punishing. In late July, Omu Fahnbulleh made the trip on the back of a motorcycle, in the rain. She was returning home after burying her younger brother, who had died from a brief, intense illness in another district. Fahnbulleh, who is thirty years old, knew that Ebola had recently spread to parts of Liberia, but, so far, no one from Grand Cape Mount had become infected. When she arrived at the small beachside house she shared with her husband, Abraham, their three children, and Abraham's family, Fahnbulleh's body ached and she had a fever; she attributed her condition to the hard journey and to the fact that she was three months pregnant.

Over the next couple of days, her condition worsened, and she asked Abraham to take her to St. Timothy, a rudimentary hospital on a steep hill above their home. There she miscarried. In the morning, a doctor collected a

blood sample and put her in isolation. Later, when Abraham visited, he was not allowed to enter the room. After a harrowing week of sharp internal pain and constant vomiting and diarrhea, Fahnbulleh was told that she had tested positive for Ebola. An ambulance van arrived to take her to the country's capital, Monrovia. By then, Abraham was also sick. They were loaded into the back of the ambulance, on stretchers side by side.

Fahnbulleh and her husband believed that they were going to a hospital. Instead, several hours later, the ambulance turned onto a narrow lane that ran past low-slung shops and shanties. Fahnbulleh realized that they were in West Point, Monrovia's largest slum. A police officer opened a metal gate, and the ambulance stopped inside a compound enclosed by tall walls. In the middle of the compound stood a schoolhouse. The driver helped Fahnbulleh and Abraham through a door, down a hall, and into a classroom. A smeared chalkboard hung on one of the walls, which were painted dark blue. Dim light filtered through a latticed window. On the concrete floor, ailing people were lying on soiled mattresses. When Fahnbulleh lay down, she saw that the two men beside her were dead.

That night, a man in a biohazard suit appeared. On his back, he wore a rectangular tank, filled with chlorine, connected by tubing to a black wand. He moved deliberately through the room, spraying the floor and walls, the patients, the two dead men. He was about to spray Abraham, but Fahnbulleh told him not to.

The next morning, another suited man brought cornmeal. Neither Fahnbulleh nor her husband could eat. Abraham told her that he felt that he would die; Fahnbulleh decided that they needed to get away from the dead men. She dragged her mattress to the hall and found an empty classroom. When she returned to fetch Abraham, he was lying on the concrete. The man in the suit was spraying him. He told Fahnbulleh that Abraham had fainted while trying to walk.

Fahnbulleh sat beside her husband and waited for him to wake up. She understood that he had wanted to follow her. After a while, she touched his mouth and felt no breath. She touched his chest and felt no heartbeat. She raised his arm, and it was limp. Eventually, she unfolded an extra shawl that she had brought with her from Robertsport and covered his face.

At daybreak, after spending the night in the other classroom, she walked out of the school. Policemen loitered in the yard. When Fahnbulleh reached the gate, they let her pass, afraid to touch her.

Her ankles had grown progressively inflamed since her miscarriage. Every step was painful as she made her way through West Point, past video clubs, fufu shops, and tables of dried fish. She headed to Clara Town, a mile away, where Abraham's sister lived, but when she arrived her sister-in-law, who had heard that Fahnbulleh was infected, refused to let her in. Unsure where to go, Fahnbulleh found a carpenter's shop and curled up amid the lumber scraps and tools. The next day, someone discovered her and called an ambulance. This time, she was taken to an Ebola Treatment Unit at a government hospital. After two weeks, she was discharged and went to a safe house in Robertsport to recover for a month before returning home. In her absence, the virus had killed others, including her father, mother, sister, and twelve-year-old daughter, Mariama.

Fahnbulleh told me this story in November, on the porch of her house. Her two remaining children chased mangy chickens through the grass. A breeze moved the palms. Nearby, one of Abraham's brothers boiled water on a fire. At several points—while explaining how the police officers at the gate of the schoolhouse had been unwilling to stop her, and how she'd walked through West Point with badly swollen ankles—Fahnbulleh grinned, rocked forward, and laughed.

One day in early November, I followed several young men down a warren of sandy alleyways, veined by rivulets of sullage, that wound through West Point, the slum to which Fahnbulleh and her husband had been taken. West Point occupies a bent thumb of land that juts abruptly from downtown; from above, it must look like a solid patchwork of corrugated tin—a rusty flotilla about to drift into the sea. On the ground, it's a labyrinth of crude squatter dwellings that accommodate some eighty thousand people. With the Atlantic on one side and the Mesurado River on the other, the slum cannot expand—it only grows more crowded. High tides regularly destroy the houses on the periphery, and, when the water ebbs, new structures are erected. Residents relieve themselves in the cramped gaps between the walls; trash is repurposed as a bulwark against eroding riverbanks. We passed dilapidated blockhouses, children

taking bucket baths, and old women spreading rice over tattered tarpaulins to dry. On the beach, fishermen sat on dugout skiffs, stitching grain sacks together to make sails.

Eventually, we arrived at a sprawling sheet-metal assemblage known as Titanic. Ebola had killed fourteen of its ninety-plus residents. The landlord, who manned a provisions shop attached to the complex, stocked with canned goods and plastic sacks of fresh water, had lost his wife and brother. The boy who was sweeping up was now an orphan. All their belongings, in accordance with decontamination procedures, had been confiscated and destroyed. The landlord built Titanic with his brother, more than a decade ago, after serving in the Army for sixteen years; the boy was the son of his former commander. The landlord had adopted the boy, and he was confident that as soon as they got Titanic back in shape renters would return. When I expressed surprise, he asked, "Where else should we go?"

In West Africa, people who catch Ebola and do not die are called "survivors." That term could apply just as well to the entire region, and to everyone in it. The World Health Organization has documented more than twenty thousand Ebola cases, including eight thousand deaths, in Guinea, Liberia, and Sierra Leone, and the real toll, no doubt, is much higher. I spent the month of November in Liberia and Sierra Leone, the two most severely affected countries, and everywhere I went the epidemic was compared to a military struggle. The language is familiar; both countries have only recently emerged from years of civil conflict that killed two hundred and fifty thousand people. Long before Ebola struck, West Africans were versed in cataclysm and what is required to endure one.

The epidemic began in December of 2013, in a small village in Guinea, when the virus spilled over from an unknown animal host into the human population. In March, patients seeking medical treatment crossed the border into Liberia, carrying the virus with them, and in May the first case was confirmed in Sierra Leone. Most health officials now agree that the epidemic could have been contained earlier, if not averted, by a more robust and better-organized international response. Previous outbreaks of Ebola had mostly occurred in remote areas, and the worst had killed no more than three hundred people before being stopped. In speaking to some local health officials, the W.H.O., which advises African nations on epidemic preparedness, had dismissed the likelihood of a major urban Ebola outbreak. When the virus reached Monrovia, in June, Liberia's health system collapsed. For most of the summer and into the fall, hospitals were overrun, the wait for an ambulance was often many days, people were dying in the streets, and infectious corpses were left in crowded homes to rot.

The W.H.O. did not declare a global emergency and call for a coördinated international response until August, and by then a thousand people had died. In October, the United States allocated seven hundred and fifty million dollars and began deploying soldiers to the region to construct Ebola Treatment Units, or E.T.U.s, set up mobile laboratories, provide logistical support, and train local medical staff. Twenty-eight hundred U.S. troops eventually arrived, following advisers from the Centers for Disease Control and Prevention. The Americans were joined by hundreds of British military personnel, hundreds of Chinese and Cuban nurses and physicians, and aid workers from international nonprofit organizations. Even so, the epidemic continues. Last month, Doctors Without Borders, which has been in the forefront of treating Ebola patients and sounded the earliest and loudest alarms for aggressive foreign intervention, published an assessment warning that efforts by donor countries "have been sluggish and patchy, falling dangerously short of expectations."

Regular West Africans, in the absence of rescue, by the world and by their own governments, which are among the poorest on earth, have proved remarkably adept at finding ways to live and to help others do so. Neighborhoods have mobilized, health-care workers have volunteered, and rural villagers have formed local Ebola task forces. Individuals who survive Ebola are usually immune to infection, and in many places they have become integral to stemming the epidemic. "Communities are doing things on their own, with or without our support," Joel Montgomery, the C.D.C. team leader in Liberia at the time, told me when I met him in Monrovia. "Death is a strong motivator. When you see your friends and family die, you do something to make a difference."

As one of Monrovia's poorest and most densely populated neighborhoods, West Point was also among the worst hit. Squalor in the slum has always outstripped sanitation, while disease—malaria, typhoid, acute diarrhea—abounds. There is no garbage collection, sewage system, or reliable running water. Initially, many residents of the slum gave credence to a rumor that the virus was a ploy to solicit foreign donor money; the theory only vindicated long-

standing disenchantment with the government. The landlord of Titanic told me, “When Ebola came here, we doubted.” The single public school that served West Point closed in July, after the government cancelled education across the country. The school was reopened in August as a holding center for Ebola patients. The government assured suspicious residents that the facility had been established for their benefit, but many of the patients, such as Fahnbulleh and her husband, turned out to be from counties as far away as Grand Cape Mount. As patients inside began to die, health officials publicly attributed the deaths to the community, and West Point residents grew more distrusting and resentful.

“They wanted it closed,” Kenneth Martu, a local organizer, told me. Martu, who is thirty-eight, was born and brought up in West Point; he frequently serves as a liaison between the slum and the government. When we met at the headquarters of an American nonprofit, in Monrovia, he was wearing a pressed shirt that strained over his broad shoulders each time he leaned across the table to emphasize a point. Martu recalled the waves of poor, displaced Liberians who settled in West Point between 1989 and 2003, during the country’s successive civil wars. “It’s a community of nobodies,” he said. “Politicians pay attention to us only when there’s an election.”

As agitation with the holding center increased, Martu tried to reassure his neighbors, but, a couple of hours after Fahnbulleh left for Clara Town, hundreds of demonstrators pushed through the gates and stormed the schoolhouse. One man carried out a young infected girl in his bare arms; other patients absconded or were expelled. Looters ransacked the rooms, running off with bloody mattresses.

The next morning, Martu and a delegation of nineteen other community representatives met with officials from the National Ebola Task Force, at its offices across town. The task force had been formed by Liberia’s President, Ellen Johnson Sirleaf, who had declared a state of emergency and warned that civil liberties might be suspended. During the meeting, officials raised the possibility of quarantining the entire slum. “We said that would not be a good thing to do,” Martu told me. “And we gave them several reasons.” At least half of all West Pointers make their living from the local fishing industry: the gillnetters who catch the fish; the service men who ferry it to shore in handmade wooden canoes; the mongers who smoke it, using salvaged metal oil drums; the market women who hawk it at sidewalk stands and street fairs. If the boats were beached, if no one was allowed to go to town, the economic impact would be ruinous.

Despite Martu’s plea, two days later West Point’s exits were blockaded with metal ramparts and barbed wire. Security forces forbade anyone to leave. Gunships patrolled the coast. As incensed residents gathered on the road, Martu was summoned by the task force. After being escorted through a buffer zone, he watched a mob approach the barricades. Helmeted soldiers beat people with batons; police in riot gear closed ranks behind their shields. Uniformed men huddled around West Point’s commissioner and several of her relatives. The commissioner, as Martu learned later, had decided to evacuate her family, which tipped the outrage into violence. As military officers shepherded the family toward the buffer zone, the mob pursued them, throwing stones. Tear gas was deployed. Martu was shoved into a vehicle. Moments later, he heard gunfire. A man and a fifteen-year-old boy were shot; the boy died.

As Martu had predicted, once the exits were sealed in West Point food prices soared. Many residents went hungry. The police had abandoned their one station in the slum, and theft ensued. Meanwhile, Ebola proliferated. It took the West Point emissaries ten days to persuade the government to end the quarantine. During the negotiations, Martu and his colleagues agreed to implement vigorous containment measures in the slum: identifying sick people, removing them from the community, quarantining their houses, tracking down their recent contacts, and monitoring those contacts for twenty-one days—the maximum amount of time the virus has been known to incubate before manifesting symptoms. Previously, all this was the responsibility of highly trained specialists. In the Democratic Republic of the Congo, where several Ebola outbreaks had occurred, epidemiologists could personally keep tabs on every household in an infected area. “That’s been our biggest challenge in this outbreak,” Montgomery, the C.D.C. team leader, told me. “In an urban setting, with an average of ten to twelve contacts per patient, it’s just mind-blowing how many contacts you end up following.”

In West Point, the job fell to the neighborhood. “We had to guarantee that the things that needed to be done would be done by ourselves,” Archie Gbessay, another local leader, who worked with Martu to carry out the interventions,

told me one afternoon in November. We were walking down the main road that snakes through West Point. Gbessay wore a knapsack filled with case-investigation forms and kept his thumbs hooked on the chest-strap clipped across his sternum. He is twenty-eight years old but exudes a quiet force that seems to have accrued over a much longer life; his face quivers with intensity when he talks about Ebola. “If we didn’t do this, nobody was going to do it for us,” he said.

To build a network of active case-finders who could cover all of West Point, Gbessay recruited three volunteers from each of the slum’s thirty-five blocks. Most of them were young and had a degree of social clout—“credible people,” Gbessay called them. The quarantine had done little to alleviate popular skepticism of the government’s Ebola-containment policies, however, and, for a while, hostility persisted. “At first, the cases were skyrocketing,” Gbessay said. “We used to see seventy, eighty cases a day. But by the middle of September everyone started to think, Look, I better be careful. Today, you talk to your friend—tomorrow, you hear the guy is gone. So they started to pay attention.”

Outside the West Point police station, we encountered a group of protesters waving signs and chanting. The Independent National Commission on Human Rights had just released a report on the shooting of the boy in August; some of the signs featured photographs of him bleeding in the street. Gbessay led me past the melee, and we soon reached the gates of the former schoolhouse. A guard took our temperatures, then waved us through. Inside, we found a half-dozen nurses, in blue scrubs, looking bored. The holding center, which had closed after the riot, had since reopened as a transit center. Now, when residents of the slum felt unwell, they came here to be diagnosed and, if necessary, wait for an ambulance that was staffed by West Pointers and managed by Martu. The average wait time had become a matter of minutes, rather than days.

In September, at the height of the outbreak in Monrovia, the C.D.C. warned that Ebola could infect 1.4 million West Africans by late January. The prediction assumed that no “changes in community behavior” would occur. By November, that assumption was obsolete in West Point. Gbessay’s active case-finders had largely prevailed on their neighbors to come forward with symptoms and observe basic precautions such as avoiding physical contact with each other and washing their hands several times a day at the hundreds of chlorine buckets stationed throughout the city. As a result, cases were waning. “Every day, patients come,” the supervisor of the transit center told me. “But it’s going down. It’s getting less and less.”

Gbessay gestured at the nurses, all of whom were from West Point, and all of whom were volunteers. “It is because of love we are in the field,” he said. “It is because of love they are here, they are working, and have not gotten a dime.” Gbessay peered at me. He wished the outsider to see. “Just because of love.”

Recently, the government had begun sending Gbessay to other communities to help set up similar grassroots initiatives. Even as Ebola was declining in the capital, new hot spots were cropping up throughout the country. It was the end of the rainy season, and Liberians were on the move: returning to their farms, visiting their families, incubating the virus. “There’s the risk of it becoming endemic, where you have this continuous cycle of infection,” Montgomery told me. He and others were concerned that if the rural outbreaks, however small, were not quickly suppressed the virus could become persistent, travelling with people back and forth between the city and the jungle. “You control it in one area and then you get transmission into another area by population movements,” Montgomery said. “So you have to completely eliminate person-to-person transmission in these hot spots.”

In mid-November, a small village called Jene-Wonde, in Grand Cape Mount County, had one of the highest concentrations of Ebola in the country. A month earlier, the U.S. military had begun rolling out a plan to install up to seventeen state-of-the-art E.T.U.s across Liberia, one of them in a town in Grand Cape Mount named Sinji. Many politicians had criticized President Obama for deploying troops in West Africa, and Pentagon officials had emphasized that no military doctors or medics would provide treatment. Although massive white and green tents already occupied a graded hilltop in Sinji, the facility there was not scheduled to open until November 30th, when enough Liberians could be trained to run it. (It finally opened in late December.)

I first visited Jene-Wonde with the county burial team, after the wife of its imam died. The team was led by Lisa Jah, an authoritative twenty-eight-year-old who, despite the heat, wore faded bluejeans and a matching denim jacket. Jah

was originally from southeastern Liberia, but had come to Grand Cape Mount two years earlier as an environmental-health technician, working for the government on public awareness of infectious diseases. She and the six men she supervised set out from Sinji in two four-wheel-drive trucks. At the end of a long and cratered road, they pulled into a small square where there was an outdoor pavilion and two weathered headstones inscribed with faded epitaphs.

Ebola victims are most contagious when they are no longer alive, and in West Africa—where burial rituals, for both Christians and Muslims, entail anointing the deceased—many people have contracted the virus from a corpse. During the summer, when Omu Fahnbulleh's family members died in Grand Cape Mount, a team had to come from Monrovia to retrieve the bodies. In August, the government had requisitioned a crematorium—built just outside the capital by the Indian consulate, for Indian expatriates—and mandated that all Ebola corpses in the city be incinerated. (The mandate has since been lifted.) Cremation is alien to Liberian traditions, and there was concern that the practice could discourage people from reporting deaths. Jah's team was established in Grand Cape Mount, in September, by Global Communities, an international N.G.O. It operates under the supervision of the county health team, which is based in Sinji and comprises various local agencies and foreign partners. As an environmental-health technician, Jah was trained in safe burials and disease prevention, and her team resumed the practice of interning victims in their home villages.

Still, until recently, Jah and her men had been unable to get to Jene-Wonde. About a month earlier, they had gone there to collect a body and had been turned back by a group of angry men wielding machetes. A couple of weeks later, two epidemiologists from the C.D.C. arranged a parley with the villagers, to find out why they were so resistant to outside intervention. The villagers admitted that nineteen people had died in Jene-Wonde since September. Early on, they said, an ambulance had taken a number of victims to the nearest E.T.U., in Monrovia. Not one of those people had been seen again, nor had health officials provided any updates on their status. If treatment meant death, the residents of Jene-Wonde reasoned, they would rather die at home.

When we arrived, several people were standing in the shade of the pavilion. Jene-Wonde's chief, Jebbeh Sannoh, wore a ceremonial head tie and a bright-colored lappa. Although Sannoh was only thirty-five, a woman, and one of the few Christians in the village, she commanded wide respect. During the meeting with the epidemiologists, Sannoh had remained silent, regarding them with a wary expression. But over the next several days she had come around and endorsed the county health team. One sign of the shift in attitude was the imam's agreement to allow Jah to bury his wife.

"Where's the body?" Jah asked when she stepped out of the truck.

Sannoh motioned to a small general store across the square. Laundry was drying on its metal roof. A dozen or so villagers crowded a veranda. The imam—an older, mustachioed man in a red caftan—sat in the middle of the group, his bare feet resting on the parapet. Jah approached him. The imam told her, flatly, that his wife's corpse was still inside their house, and he assured her that he would be quarantining himself in the home of his other wife, who owned the store.

Jah called over the two members of her team who were responsible for disinfecting. Many West Africans fear sprayers. It is a common belief that the liquid in the tanks is poison, and that this poison, not any virus, is what kills you. Jah had a plan to debunk the misconception. She showed the imam a bag of powdered chlorine, explained what it was, and let him watch as she scooped a spoonful into a bucket of water provided by a villager. The imam nodded, impressed by the demonstration. Then he got up and walked Jah to the house that held his wife.

A driver parked one of the trucks near the front door, and Jah's team began the tedious process of donning their gear. Jah looked on, chastising the men for any lapses. A few villagers gathered to watch. The spectacle, by now, was familiar. When they were ready, Jah told them, "Go in, it's to the left."

The sprayers went first—a pair of minesweepers clearing a path. Then the others entered with the bag and the stretcher. They emerged several minutes later and loaded the corpse into the back of the truck. As the truck made its way across the square, women and children spilled out of their houses, sat down in the dirt, and keened. I followed on foot, along with a few locals, all of whom turned back when the truck stopped at a wall of trees. The team filed

down a narrow trail, carrying the stretcher through dark jungle. After about a hundred yards, unmarked mounds of rich orange soil rose here and there from the grass. Beside a shallow, rectangular hole, an elderly man in flip-flops, cargo shorts, and a white skullcap leaned on the handle of an old spade. He had dug all the graves. No one else from the village, he told me, was willing to tread in that place.

The team lowered the imam's wife into the grave. On top of her, they dropped a heap of freshly hacked branches and leaves. Then they stripped off their suits, gloves, and masks and deposited them in the grave as well. When we got back to the square, more members of the health team were pulling up in trucks and Land Cruisers. The county health officer had come to Jene-Wonde to importune its leaders. Under the pavilion, three elders seated themselves behind a wooden table, assuming regal frowns. Sannoh sat in a plastic chair. The imam opened the meeting with a prayer.

The health officer, Lorraine Cooper, was a physician and former hospital director. A charismatic speaker, she addressed the villagers in the booming and mellifluous cadences of Liberian English. After an emotional plea for the residents of Jene-Wonde to forgive the county health team for its failure to keep them informed about their loved ones in Monrovia, Cooper leaned forward. "I beg you," she said. "We have come here today to find out if people are still sick among you."

Sannoh and the elders assured Cooper that the imam's wife had been the last sick person in Jene-Wonde.

On our way out of the village, we passed through a deserted bazaar. In July, President Sirleaf closed all general markets near the country's border, and the empty wood stalls, half-collapsing from disuse, felt like pillaged ground. Behind them stood a former health clinic that was being converted into a rapid-response center. Two weeks earlier, Sannoh had met with the C.D.C. epidemiologists and agreed to enlist a group of local men to work on the building. The project was part of a national plan to supplement the large-scale E.T.U.s that the U.S. military was putting up with more easily deployable facilities appropriate to the emergence of hot spots in far-flung villages. Once the rapid-response center was completed, sick people could be isolated and tested for Ebola without having to leave the village.

Until then, it seemed certain that some residents of Jene-Wonde would continue to reject treatment. The day after Sannoh and the elders promised Cooper that everyone was healthy, Jah and her team were called back to Jene-Wonde. Two middle-aged women had died during the night, and three men were violently ill. Although one of the men agreed to go with the ambulance, the others refused.

After the ambulance left, I found Sannoh in the square, sitting on a raised slab that extended from the pair of ancient headstones. The sick men who had insisted on staying were still inside their houses, with their relatives, and I asked Sannoh what she planned to do.

"They are afraid," she said. "The person goes, and doesn't come back. Who knows?"

To propagate, some viruses take advantage of their hosts' eating habits, others their reproductive habits, others their migratory habits. The human qualities that Ebola has most ruthlessly exploited are empathy and the impulse to assist and comfort people who are suffering. Fear of Ebola, on the other hand, can completely suppress these impulses. Vigilance can give way to stigmatization, caution to callousness. This is something that communities as insular and self-reliant as Jene-Wonde cannot afford.

One day, while I was walking through the village with Sannoh, she pointed out a young boy, Ben Ballah, who was playing under some trees with several friends. Ben's father had been the first person in Jene-Wonde to die from Ebola. Later, his mother, his sister, and three brothers had died. Each time another family member fell ill, Ben's twenty-one-day quarantine would reset. Even when I saw him, he should not have been outside. At the time, eleven households in Jene-Wonde, with a hundred and eight inhabitants, were quarantined. They were identifiable by blue plastic barrels outside their doors, in which neighbors deposited water, food, and firewood. Isolation is onerous in rural communities where most families depend on subsistence farming and no longer have markets for trading.

Although the World Food Program supplies quarantined households with rice, beans, and oil, the rations are sometimes slow to arrive, or never do.

In Bowaterside, a larger town in Grand Cape Mount, I met two siblings, seven-year-old Augustine and his six-year-old sister, Kou, who were quarantined in a mud house by themselves. Ebola had arrived in the town in late September, when the drug dispenser at the local clinic fell ill. She had given herself a diagnosis of typhoid and told her neighbors that she was not contagious. The children's mother, a close friend of the woman, subsequently died. So did their infant brother. Their father had left a year earlier, to work in a gold mine; no one had heard from him in months. During most of Augustine and Kou's quarantine, their ten-year-old sister, Massa, had been with them. Then Massa developed a fever and was taken to Monrovia.

The house was one among a cluster, set back from the road, with a roof poorly fashioned from sheet metal and palm leaves. Augustine and Kou sat on a low bench just inside the doorway. Earlier, representatives from the United Nations Children's Fund had paid a visit, bearing toys. Augustine wore a red firefighter's helmet and held a plastic space gun. A doll was strapped to Kou's back. Their bed, a stain-covered duvet, lay in the dirt to dry.

I'd come to Bowaterside with a young woman who used to run the clinic in Jene-Wonde and was now a social worker with the county health team. Neighbors gathered around her, agitated. The children's aunt, who had been setting daily bowls of rice outside their door, complained that she could no longer feed them. She used to sell cassava garri at the local market: now, with the market closed, her own children were at risk of going hungry. A neighbor, Lawrence Magoma, said that rain was leaking through Augustine and Kou's roof, and he was upset that the village had yet to hear any news about Massa. If Massa tested positive, Augustine and Kou would have to start their quarantine all over.

"We told the ambulance!" Magoma shouted at the social worker. "When they carry patients to the hospital, they do not check back. You cannot carry patients and then you just abandon that patient! How will we be in contact? We care for our people!"

The social worker opened her arms, in appeal. "We ourselves, we are concerned," she said. "It's really bothering us. I beg you, people, let's just hold our peace for now." She promised to find out about Massa, but she wanted Magoma's assurance that Augustine and Kou would remain sequestered in the house until she confirmed that their sister was negative.

Magoma shook his head and sighed. "These children," he said, "they are only surviving through the mercy of God and these people here."

From the doorway, Augustine and Kou watched mutely.

Not far from the house, a metal gate blocked the road; on the other side was Sierra Leone. Before the border here was sealed, in July, the market where Augustine and Kou's aunt sold cassava garri, and where their mother sold fufu, was held on Fridays in Sierra Leone and on Saturdays in Liberia. Some forty illegal routes, on the outskirts of Bowaterside, still linked the two frontiers.

In November, the W.H.O. recorded more than eighteen hundred new cases of Ebola in Sierra Leone, three times the number in Liberia. So far, the epicenter of the outbreak has been the capital, Freetown. After witnessing the meltdown of the health system in Monrovia over the summer, responders in Freetown have worked hard to stave off a similar catastrophe. In the offices of the British Council, a large auditorium serves as a command center to manage response efforts in the city. (Throughout the epidemic, Britain has led foreign assistance for Sierra Leone, which was once a British colony.) In October, the Minister of Defense was appointed head of a new committee responsible for confronting Ebola, and the command center is a quintessential war room. Operational flowcharts cover the walls; colored pushpins dot giant laminated maps; tracker boards catalogue daily "live" and "dead" alerts received through an emergency hot line that people are supposed to call whenever someone becomes sick or dies. A British Army major presides, unflappably, over the various sections.

Despite the impressive logistical orchestration, six months after Ebola arrived in the country, actual resources remained unequal to dealing with the epidemic. The system that the hot line was meant to activate was overloaded. All of Freetown's hundred and twenty treatment-center beds were occupied. The holding center in the country's main hospital had been continuously full since August. Outside the hospital, patients were obliged to wait in a makeshift tent, sprawled on sheets of cardboard, sometimes for two days. "We've always felt like we're six weeks behind Liberia," Oliver Johnson, who heads a team of British advisers at the hospital, told me. "Liberia was worse, so a lot of organizations were going there. If they had the capacity to set up one treatment unit, they were doing it in Monrovia." (By late December, more E.T.U.s had opened, relieving the backlog.)

In the rural provinces, the virus has travelled on the backs of motorcycle taxis deep into the jungle and across mountains, reaching places that make Jene-Wonde look metropolitan. Attempts to identify and quell hot spots in the countryside have resembled a game of Whac-A-Mole, with the mallet invariably landing late. In Tonkolili, a twenty-seven-hundred-square-mile district in the very center of the country, I accompanied the district surveillance officer to a village where Ebola had recently killed more than thirty people before officials found out. To get there, we followed barely discernible tire tracks, for miles, through grass so tall and close you felt as if you were in a car wash; no one in the village had a cell phone or had heard about the hot line. The local chief, or headman, had been told that somewhere a plane had crashed and for every passenger who died a villager must fall ill. The headman wore a ski cap and a trenchcoat and sat squarely in the sun. When I asked about the plane crash, he explained, "That was the information that we had. We have our culture. We believed. Now we know they were wrong reports." The surveillance officer, along with advisers from the C.D.C. and a higher-ranking chief from the area, had intervened in the village only two days earlier, and the headman had already implemented their recommendation to form a task force, much like Gbessay's active case-finders in West Point, to seek out sick people and quarantine their contacts.

I discovered similar task forces almost everywhere I went. Most of them had been formed in reaction to a rash of deaths. When Ebola finds its way to secluded communities, the impact can be devastating. In the far east of Tonkolili, we drove down a road so ravaged and seldom used that we had to ford creeks and stop several times to pry boulders out of the way. The road led to a village where twenty-two members of the same family had died. The virus had been introduced by the local imam, after he travelled to the capital to care for and bury his infected son. Shortly after the imam returned, he and several of his relatives succumbed. "We'd never seen anything like that before," the headman told me. "People began to die in twos and threes. Everyone was scared. Overwhelmingly scared. It put terror in our hearts." We were sitting outside the mosque, surrounded by the dozens of villagers who remained. Several of them were survivors; many of them looked underfed. While Ebola rampaged through the village, people had been too afraid to leave their houses and had left their farms unattended. Insects had destroyed the harvest.

The headman was the son-in-law of the imam. He had struggled to prevent his wife and fifteen-year-old daughter from going to him. His wife relented; his daughter did not. "She loved her grandfather very much," he explained. "I tried to keep her away, but I could not." She later died.

Another young relative, a niece of the imam, lived outside the village, in a concrete house shared by three brothers and their wives and children; soon, the headman heard that she, too, was sick. Each time he went to investigate, he found the house abandoned. "They moved into the bush," he told me. "They kept moving their location. I just wanted to fish out the infected girl. But they hid her." Eventually, the girl died, followed by her mother, father, and infant sister. "Then we suspected that somebody else was sick," the headman said. "We tried to go there, to cajole them, and they refused. We got to know that two more among them had died and they had buried them in the bush. They are very stubborn."

When I went to the house, which was painted yellow and brown and looked as if it had several rooms, it appeared empty. Wood shutters blocked the windows. I called through the door several times. After a while, a teen-age girl emerged with a baby on her hip. Then a young boy joined her. Then another child, and another, and another, until more than a dozen stood outside: barefoot and dirty and too thin. They were the siblings of the first sick girl. When I asked who took care of them, they said their uncles. Both men, who had fourteen more children between them, lived in the jungle.

One of the boys led me into the trees, and, after a few hundred yards, we came to a small clearing. Two flimsy huts, made of branches and palm leaves, stood side by side. A broken pot sat in a pit. A few chewed ears of corn were scattered on the ground. The two uncles were there. Both men wore filthy rags. They told me that more than thirty of their relatives were currently staying in the bush. A few days earlier, an ambulance had taken away their dead brother's second wife and her two sons. I asked whether any health officials were aware of their situation, and they said no. They didn't seem interested in receiving food rations; they preferred to be left alone. I'd seen families like this before: hungry, homeless, traumatized, and fearful and suspicious of everyone. They were refugees.

In Tonkolili, even when infected victims were identified promptly, treatment was very far away. From the district capital, Magburaka, the drive to Freetown—on a paved highway whose only obstacles are periodic military checkpoints and a few farmers spreading grains of rice to dry atop the baking asphalt—takes about three hours. But, because all the E.T.U.s in the city were at capacity, patients who tested positive for Ebola in Tonkolili had to be transferred to an E.T.U., run by Doctors Without Borders, that sometimes took nine hours to reach. (Doctors Without Borders has since opened another E.T.U. in Magburaka.)

The ambulance, a four-wheel-drive Land Cruiser with a blue light on the roof, left almost every morning from Tonkolili's main holding center, a small government hospital in Magburaka. Early one morning, I found the Land Cruiser parked near an open breezeway outside the isolation ward. The breezeway was blocked off at both ends with tape and pink sheets that read, in black marker, "Ebola Is Real." Armed soldiers stood guard. The first patient to emerge from the ward was a nineteen-year-old girl. She wore a striped skirt and looked frail. Her two younger sisters were already undergoing treatment at the E.T.U., and she had told a nurse that she was frightened to join them. As the girl hiked up her skirt and struggled to step onto the rear bumper of the ambulance, the nurse and two drivers stood back several feet and watched.

"Don't be afraid," the nurse called, in Krio. "Other people have gone there and come back."

The girl nodded.

In a lower voice, to the drivers, the nurse said, "She's been vomiting a lot."

The drivers, thirty-four-year-old Abdul Kamara and thirty-five-year-old Idrisa Conteh, were brothers. In August, when Ebola became more than a sporadic problem in Tonkolili, Kamara had been the only ambulance driver in the district. Soon, he was taking patients to the distant E.T.U. several times a week. Even if he left by dawn, he often didn't get back until three the next morning. There was no air-conditioning in the Land Cruiser, and, when patients were in the back, he had to wear a suit, a hood, three pairs of gloves, a mask, and heavy rubber boots. The heat was powerful. For relief, Kamara liked to pour water over the outside of his suit and feel the lukewarm liquid trickle over its impermeable polyethylene. By the time he arrived back in Magburaka, a puddle had formed on the floorboards, which he cleaned. During a trip in September, one of Kamara's passengers vomited and defecated profusely, and some of the fluids seeped beneath the barrier between the rear compartment and the cab, mixing with the water on the floor. A few days later, Kamara woke to a pain in his side. He was taken to an E.T.U. that treated health-care workers and was given a diagnosis of Ebola; after two weeks, he became one of the first ambulance drivers in the country to survive the virus.

Before falling ill, Kamara had recruited Conteh, who had previously imported and sold motorcycles from Guinea, and a family friend to help him. At the time, they were volunteers; later, the government pledged to pay them ninety-five dollars per week, but Kamara and Conteh told me they had yet to receive the salaries. By November, Kamara was mostly working as a mechanic for the district, while Conteh and the friend alternated between collecting patients from the villages and making the long haul to the E.T.U. (I met Kamara when my car broke down and he appeared on a motorcycle, with a toolbox strapped to the rear seat.) The morning I visited the holding center, it was Conteh's turn to go. Under the breezeway, Kamara watched his brother don his gear and stock the cab with water.

Meanwhile, another teen-age girl and a boy squeezed into the back, on a short bench seat opposite a gurney. The gurney was reserved for an elderly man who was pushed out of the ward in a wheelchair by a hospital attendant in full protective kit. It took a while for the attendant to get the man out of the chair and onto the gurney. The man

wore a black fedora and a collared shirt. He was very weak and seemed embarrassed to be causing so much inconvenience.

"Lie down now," Conteh said softly, and the man obediently curled up on his side.

"Will he survive the road?" Kamara asked the nurse.

The nurse wore a surgical mask; her expression was inscrutable. She said again of the first girl, "And she's vomiting."

Sometimes, Conteh and Kamara told me, when the E.T.U. attendants opened the back of the ambulance they found that one of the passengers had died on the way. The hard journey reduced others to a state of such fatigue that they died one or two days later.

The nurse gave each patient a plastic bag containing two pieces of bread and a hard-boiled egg. It looked very crowded back there, and Conteh still had to pick up a fifth person at another holding center. He kicked shut the rear doors, careful not to touch them with his hands. Then he got into the cab, turned on the blue light, and pulled onto the road.

Later, I learned that during the drive the ambulance broke an axle. At the holding center, Conteh had forgotten to move the jack from the back of the Land Cruiser to the cab: he had to retrieve it from where it was stowed among the passengers. He fixed the axle and delivered the patients to the E.T.U. Not long after he returned to Magburaka, he told Kamara that his head hurt. Kamara arranged for him to be taken to a treatment facility, where, ten days later, he died.

Recently, on the phone, Kamara told me that he still has not been paid and was having no success recouping the salary that Conteh, who left behind four children, was owed. The day Conteh left on his last trip to the E.T.U., I had asked him why he did what he did. "This is my land," he said. "I am fighting for my land."

According to the W.H.O., an outbreak is not over until no new cases have occurred during the length of time that is twice the incubation period of the virus—forty-two days for Ebola. No one knows when that will happen in West Africa. Even when it does, the threat will persist. "The virus is not going to go away," Montgomery, the C.D.C. team leader in Liberia, told me. "We will stop this outbreak. Person-to-person transmission will stop. But the reservoir is still out there."

The trauma done to West African society will last for years. Thousands of survivors are already struggling to return to communities that have been inundated with public-awareness campaigns geared toward inculcating a fear of Ebola, and no one knows how many orphans the virus has left behind. When Omu Fahnbulleh returned to Robertsport, to discover that in her absence most of her family had died, people followed her down the street, taunting her. Her husband was a carpenter; now that he is gone, she is unsure how she will support her children. "I got no one to help me," she told me when I met her. "I'm not getting nothing. I'm not doing nothing." Communities, employers, friends, sometimes even relatives shun survivors. In Tonkolili, I accompanied a social worker who was escorting a teen-age survivor back to her village. The girl's neighbors and family were clearly uncomfortable, and one woman asked whether it was safe to touch her. "She is free," the social worker said. "You are vulnerable; I am vulnerable. But she is free."

In Monrovia, I heard several stories of survivors returning home to find that their apartments had been leased to other tenants. Even when that didn't happen, many of their belongings had been incinerated. The Liberian government issues "survivor kits," which include bedding, rice, and basic cookware, but I met many survivors who said they never got them. In Sierra Leone, it was left to the E.T.U.s to send something home with discharged patients. The teen-age girl in Tonkolili had been given a bucket containing two plastic cups, two plastic bowls, a mosquito net, a sleeping mat, a thin blanket, a toothbrush and toothpaste, three bars of soap, a towel, sanitary napkins, used T-shirts, a baby's flip-flops, infant-size underwear, and a baby's corduroy trousers.

Last summer, the Liberian Ministry of Health asked Korlia Bonarwolo, a physician's assistant in his mid-twenties, to launch a new department that would help survivors reintegrate into society. When I met Bonarwolo, in Monrovia, he had just left the government, which he found cynical and ineffective, to form his own association. Bonarwolo described Liberia's reintegration initiatives as a public-relations exercise put on for the benefit of donors. "They were using us," he told me. He said that the government had mostly arranged for him to appear at organized events, and did not provide real resources to assist survivors.

Bonarwolo contracted Ebola in late June, while caring for one of his colleagues at Redemption Hospital, in Monrovia. He was at home when he first recognized that he was ill. No ambulance was available at Redemption and after three days a friend took him to John F. Kennedy Medical Center, another treatment unit in the city. He was put on a gurney, in a fenced-off area outdoors, in the rain. Two other patients were isolated alongside Bonarwolo, one of whom suffered frequent fits of rage. "One time, she dragged me to the floor and jumped on my back," Bonarwolo said. "She beat me until she got tired. It was just by the grace of God she didn't kill me."

Bonarwolo was in the E.T.U. for three weeks. After his discharge, he contracted pneumonia and became anemic. Still, the more survivors he met, the luckier he felt. Many had nowhere to live and could barely feed themselves. The girl who had abused him in the E.T.U. had survived but remained unstable. Her family had given up on her, and she was living in a church.

One of the co-founders of Bonarwolo's new association was a survivor in her early twenties named Deconteh Davis. She had been infected in July, by an aunt of her fiancé. Four days after Davis was admitted to an E.T.U., while she was lying on a gurney in the corridor, she recognized her fiancé's screams when he was brought into a nearby room. Too weak to move, Davis lay in the corridor and listened until he was quiet. Eventually, someone told her that he was dead.

Two weeks later, when Davis walked out of the E. T. U., one of the first people she encountered was Bonarwolo. She began attending weekly meetings at the Ministry of Health, where she was approached with a job offer. The government was opening a quarantine center for children whose parents were infected with or had died from Ebola. Because the children had the potential to become contagious, the center needed to be staffed by survivors. Davis, who was a Sunday-school teacher and had worked with children for a Christian charity, agreed to be the supervisor.

When I visited the quarantine center, in Monrovia, a group of children sat in plastic chairs inside the gate, near a metal seesaw. Girls braided one another's hair. The oldest, who was thirteen, bounced an infant on her knee. Davis, who seemed to be smiling even when she scolded the children, radiated an energy that precluded gloominess in anyone around her.

Once the children have spent the requisite twenty-one days at the center, they are supposed to be reunited with living relatives, typically aunts and uncles. As of November, no official provision had been made for those without aunts and uncles, or for those whose aunts and uncles declined to adopt them.

Children who contract Ebola and survive are a separate matter. As soon as they are discharged, if their parents are dead they go to an orphanage that is an hour and a half outside Monrovia, in the vast rural flatland near the airport and the crematorium. The orphanage is run by Hawa Massaquoi, a middle-aged woman who, before the outbreak, ran a day-care center there. A low, tin-roofed structure contains one room for the boys and one for the girls. Most of the activity takes place outside, on four wooden benches arranged around the trunk of a giant mango tree full of nests and raucous birds.

In addition to caring for the orphans, Massaquoi must learn, from them, where they are from, and to whom or what place they can return. Sometimes, with the younger and more traumatized orphans, this takes time—a gradual building of trust. Massaquoi seemed suited to the job. Numerous children constantly competed for her attention, which she distributed generously.

One afternoon, I was sitting under the mango tree with Massaquoi and a nine-year-old boy whom she had been trying to draw out for more than two weeks, without success. As she joked with the boy, a Land Cruiser pulled into

the lot. A social worker from the Ministry of Health stepped out. In the back sat two survivors, a boy and a girl. The boy, Abraham Korba, was eight years old; the girl, Manu Paye, was seven. They both wore adult-size T-shirts that fell below their knees. (The clothes that Ebola patients wear when they enter an E.T.U. must be burned.) Abraham's T-shirt was from an old political campaign and featured an image of President Sirleaf beneath the faded words "For the Good of the Country."

While Massaquoi spoke with the social worker, Abraham and Manu silently watched the other children dance to a song playing on the Land Cruiser's radio. After a few minutes, the social worker handed Massaquoi some paperwork and left. "This is all they give us," Massaquoi said, flipping through the documents. Each discharge form was a single page. The address provided for Manu was Kakata Highway, a road that spans several towns; there was nothing for Abraham.

Massaquoi looked down at her new charges, their hands squeezed between their thighs, faces sullen. "They just came," she said. "Maybe they don't want to talk to me. Maybe after a day or two."

I returned a week later, and almost everyone was under the mango tree, talking and laughing. Manu had new clothes and was sitting on a bench next to a girl named Esther, whose parents, grandparents, and six siblings had died. Esther and Manu had put their mattresses beside each other, and they spent their days playing together. Manu had told Massaquoi where she was from, and Massaquoi had managed to contact her uncle, who was coming for her.

I found Abraham sitting alone, wearing the same campaign T-shirt he'd been discharged in, scribbling jerky lines on a sheet of paper with a broken pen. So far, the only word he had uttered was his mother's name; according to Massaquoi, he called for her repeatedly during the night. Frowning at Abraham, Massaquoi shook her head. "He wasn't born like this," she said.

As I was driving away, I looked back and saw about a dozen children, including Abraham, huddled around Massaquoi—clutching her arms, her legs, the edges of her clothes, any piece of her that they could reach. ♦