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Epidemics in Guinea: From Infectious Politics to Viral Ontologies

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Abstract: The present article examines the application of epidemic response models on Guinean territory during the Covid-19 pandemic and questions the observable divergence between said models and implemented caregiving and epidemic management practices. Firstly, the article examines how barrier measures (masks, distancing) collide and challenge healthcare workers' "practical norms" in healthcare centres. Through this, the study aims to break with prevailing notions of Guinean – and more widely African – health care systems as dysfunctional, as well as with the interpretation that healthcare workers' and the general public's non-compliance with protective measures represents resistance or reluctance. Secondly, this paper explores how the ontological approach enables the examination of processes including translation, adaptation and appropriation during the implementation of epidemic management models by healthcare workers and the local public. Thirdly, the paper analyses how, through the mobilization of various tactics and ontological repertoires, patients manage epidemic risk in treatment centres (CT-Epi) and navigate the invisible world of viruses. Through the analysis of the Covid-19 response in Guinea, and drawing on an innovative ontological approach in Africanist anthropology, this paper aims to reconsider former theories and concepts relating to the supposed failures of African systems and to propose new axes of analysis for African contexts.

Keywords: Guinea, Covid-19, anthropology, ontology, virus

Introduction

Guinea's long history of epidemics (Le Marcis 2021), in association with recent outbreaks and resurgences[1] and a fragile healthcare system, has contributed to making the country a priority for global health organizations and epidemic surveillance policies. The 2013–2016 and 2021 Ebola outbreaks, as well as the Covid-19 pandemic that started in 2020, allowed for the implementation of formalized epidemic response models (Gomez-Temesio & Le Marcis 2017) and epidemic surveillance networks by international[2] and national[3] organizations. In fact, national healthcare organizations significantly contributed in the expansion of globally accepted healthcare practices and discourses throughout Guinea. However, while response models may appear as neutral and apolitical (Bardosh 2016), they do contain specific conceptions of disease, the body, care and viruses from modern biomedicine (Bonnet 2003) that differ from local conceptions. When formally applied during epidemic resurgences or surveillance phases, these models penetrate Guinean local society and import discourses that are ontologically situated despite their apparent universality. They then enter into negotiation with local actors and their own ontological repertoires (Fairhead 2016).

Coming from philosophy before being reinterpreted and used in anthropology at the end of the 20th century (Nef & Schmitt 2017), ontology[4] relates to "being" and the existing. Descola (2005:176) therefore defines ontology as "systems of the properties of existing beings; and these serve as a point of reference for contrasting forms of cosmologies, models of social links, and theories of identity and alterity". In anthropology, numerous authors draw on the ontological approach to account for the multiplicity of worlds and beings. If some postulate that the world is intrinsically multiple (Descola 2005), others propose to grasp the radical alterity of these worlds (Chandler & Reid 2018) via a fluid and contextual conceptualization (Fairhead 2016) of ontologies as performances (Mol 2002). The ontological approach constitutes a methodological tool to ask ontological questions (Holbraad & Pedersen 2017).

This article analyses the application of epidemic response models on the Guinean territory during the Covid-19 epidemic and questions the often-visible divergence between these models and actual epidemic management practices observed in the field. The study aims to break with prevailing notions of Guinean – and more widely African – health care systems as dysfunctional (Jaffré & Olivier de Sardan 2003), as well as with the interpretation that healthcare workers' and the general public's non-compliance with protective measures represents resistance or reluctance (Somparé 2020).

The article thus explores how Covid-19 management measures, supposed to be enforced by frontline healthcare workers, conflict with their actual practical norms (Olivier de Sardan 2010). It offers to analyse these frequent discrepancies not in terms of failures, but as processes of translation, appropriation, transformation and rejection at work when different worlds, embedded within local and biomedical discourses, encounter in the field. Second, this paper highlights the relevance of an ontological approach applied to African contexts – yet little developed on the continent – and demonstrates how this renewed theoretical approach enables to examine such contexts from a fresh perspective. Doing so, it aims to question discourses produced on Africa that continue to inscribe the continent within power relations and hierarchies with another epistemic referential – formerly European, now Western. Third, this article re-examines the Covid-19 crisis in Guinea in the light of the ontological approach. Thus, it analyses how disease and viral risk management translates, within the CT-Epi in Guinea, into a constant negotiation between humans and viruses, via avoidance and cleansing tactics that give substance to the invisible virality. This negotiation transforms viruses into acting non-humans and results in patients mobilizing various and often contradictory ontological repertoires to cure themselves and to make sense of illness.

1 Among others, Ebola, Covid-19, and the Marburg and Lassa fevers.

2 Médecins sans frontières (MSF), Alliance for International Medical Action (ALIMA), Fonds des Nations unies pour l'enfance (UNICEF), etc.

3 Agence nationale de sécurité sanitaire, Institut national de santé publique, ministère de la Santé.

4 From ancient Greek ontos, "being", and logos, "discourse, treatise".

This article draws on an ethnographic study led in Guinea from December 2020 to December 2021 within the ARIACOV research project ("Supporting African response to Covid-19 epidemics[5] "). Using participant observation and formal and informal interviews, I led fieldwork in two health facilities: an improved health centre (or CSA) integrating a basic surgery unit in the region of Forécariah, and the Gbessia Epidemic Treatment Centre (or CT-Epi) which treated Covid-19 patients in Conakry. My research at the CSA focused on the relations between healthcare workers, viruses and protective measures during the pandemics, on a cumulative period of two months (December 2020, July 2021, December 2021). At Gbessia CT-Epi, where I entered as a Covid-19 patient during the month of February 2021, I investigated the daily practices of viral risk management deployed by Covid-19 patients..

Rethinking dysfunctions, failures and reluctances

Dysfunctional healthcare systems, practical norms and non-compliance with protective measures

> "Here, we don't like masks. It is better to not wear it. There were demonstrations against it and, since then, it is not well seen to have one".

Ms. Camara[6], the midwife, gave me a heavy look while I put the surgical mask in my bag. It was December 2020, the 9th, in the midst of a Covid-19 wave, and though protective measures were supposed to be enforced throughout the country – as per a presidential decree – nobody was wearing a mask or respecting social distancing at the CSA. For several days, I had been leading fieldwork in the maternity ward alongside midwives, doctors, technical health assistants (ATS) and hospital cleaners. At the height of the epidemic, we shared the same food, eating with our right hand in the same plate, and we all slept in the same staff room. I got lucky as I shared a mattress on the floor with the head midwife, while trainees shared a second bed, a mat, or slept on benches or exam tables. No one followed social distancing rules, nor wore a mask. If we had, it would not have been possible to eat or sleep at the CSA considering the CSA's layout and the healthcare workers' management practices. Lack of space did not allow for physical distancing for either healthcare workers or patients. Moreover, in a healthcare system in which a majority of healthcare workers are considered as "trainees" and therefore not paid, it was the full-time staff that provided meals for the night shift team in a shared plate. Commensality and promiscuity are thus constant features of healthcare centres in Guinea, as is the lack of medical material. The gynaecologist entered the labour room and scolded a midwife:

> "You, there, you do not have the equipment! You don't even have a mask, whereas we are in an epidemic! You don't even wear the whole gown: you need the trousers too, a wrapper like that, it is not possible!"

He turns to me and adds:

> "Here, no one respects protective measures. Not even the doctors. People say that Corona is for the White, for the Rich. They trust that, for them, in their fields, nothing can happen! So they don't wear a mask".

Thus, standards set by national and international health organizations strongly differ from actual practices observed at the CSA. This gap applies to healthcare procedures as much as IPC (Infection Prevention and Control) and hygiene standards or epidemic response measures. If these specific flaws can be interpreted as poor practices from the part of healthcare workers, they actually manifest a greater precarity of the Guinean healthcare system, which is is defined by shortage in medical resources and clientelist relationships between healthcare workers and patients. A large majority of healthcare professionals are not officially employed by the State and work as unpaid trainees, up to ten or fifteen years for some, a status that does not reflect their actual work within the hospital. In this context, most healthcare workers charge patients for state-funded care (e.g. caesareans, vaccinations) and illicitly sell medications, competing with the official hospital pharmacy. While these practices – common to other healthcare structures in West Africa (Jaffré 2003; Tantchou 2021) – may seem as corruption (Olivier de Sardan 2010), the caregivers' objective is less to extort money from the patients than to guarantee they manage to do their work and provide care in a context defined by a lack of material and financial resources and by the non-recognition of their status by the State. These "practical norms", differing from official standards issued by institutions, are analysed by Olivier de Sardan (2010) as the product of a local professional culture (2001) and as the result of translations and appropriations of official norms by local actors – these official norms encountering and sometimes clashing with local contexts and realities (2010). The discrepancies between local contexts and institutional norms frequently lead to a "revenge of contexts" (Olivier de Sardan 2021), occasionally resulting in official standards being impossible to implement – as it was the case with Covid-19 epidemic response measures at the CSA.

At the crossroads of multiple worlds: from « failed » Africa to ontological innovations

In Africa, the divergence between practical norms in the field and official standards is often perceived in terms of failures, malfunctions, or as evidence of a "failed" state

5 Funded by the French Agency for Development (AFD) in the 'Covid-19 – Health in common' initiative and carried by the French Institute for Sustainable Development (IRD), the ARIACOV research project is led in Guinea by the Guinean Research and Formation Centre in Infectiology (CERFIG). Its social science component, named "Ebola's shadow on the SARS-COV-2 epidemic: Analysis of public policies, actors' practices and local representations of Covid-19 for a better response to the pandemic in Guinea" is directed by Prof. Frédéric Le Marcis.

6 Informants' names have been modified in the article to maintain their anonymity.

(Gaulme 2011) – drawing on an evolutionist perspective that is not social but political. In Guinea, healthcare system deficiencies are largely accepted as indisputable facts (Somparé 2017). However, it is necessary to question this assumption, and more broadly, the assumption that African States and Africa in general are failed, which generates and perpetuates unequal power relations between different actors and their respective worlds. It is crucial to go beyond the demonstration of practical norms' non-compliance with official standards and of the failure of the Guinean healthcare system in comparison with a global model designed by institutions. To do so, I propose to analyse the actual contexts in which these norms are practiced and relevant in order to account for local contexts and reclaim their epistemic legitimacy. Thus, far from resulting from systemic failures – a conceptual framework that reinforces the notion of a unique referential and, consequently, of African contexts that do not "work properly" – these divergences can be analysed as products of encounters between global institutional standards and local ways of being in the world. They emerge from processes of appropriation, transformation, and rejection at work when different worlds encounter to define a common reality. Therefore, practical norms constitute practices and discourses that allow encounters of these worlds to work "in practice" and generate a new hybrid world – an "ontological innovation" (Thompson 2005) – in which actors navigate and which "works" despite its internal contradictions. In Guinea, the practical norms of healthcare workers do not result from a frail healthcare system, but from the internal working of a healthcare system in constant negotiation between global models and local contexts. These contexts are defined by lack of resources and a crisis of confidence between the population and State actors in general (Attas *et al.*, 2021).

Thus, in order to move away from a biased and negative view of a failed Africa (politically, economically, and in its healthcare systems), I rely on an ontological approach to explore from a fresh perspective practical modalities of epidemic risk management by local populations and healthcare professionals. Constituting a paradigm shift from previous theoretical approaches, the ontological approach aims to elevate cultures and their specific beings (humans and non-humans) in valid and coexistent worlds. Far from considering cultures as specific interpretations of a unique reality (Henare et al. 2006), the ontological approach draws on the idea that alternative realities coexist as worlds in themselves. However, this approach and the paradigm change it represents – by challenging and questioning knowledge systems hierarchy and the domination of a modern Western reality that has become global – have been rarely utilised to analyse the African continent. Indeed, the ontological turn is the specific product of an anthropology that has largely developed in Latin America due to its particular political and epistemic history, which differs to that of Africa. Both continents have given rise to different anthropological traditions and currents – with their own specific themes – reflecting their political, cultural, and economic history as much as the ways in which they have been conceptualized by colonial powers and Western thinkers.

The relevance of an ontological approach in Africa

The ontological turn: Between colonial epistemologies and anthropological traditions

Anthropology developed in the 19th century as a science and a discipline in a colonial context defined by the discovery of "primitive people" (Deliège 2006) and alterity. One of its founding theories was social evolutionism (Tylor 1871), which ranked different human societies on a hierarchical scale of evolution. In this context, first works on Africa presented primitive and timeless societies frozen in an immutable past (Grinker et al. 2019) and focused on specific themes reflecting this view: witchcraft, kinship, religion, disease and care, economy and art. At the same period, Americanist anthropology focused on indigenous peoples, antiquities (via archaeology and history in particular) founding myths, and warfare in societies associated with ancient civilizations having written and printed sources (Gruzinski & Bernand 1992). While many countries in the Americas gained independence in the first half of the 19th century and became sovereign states, Africa remained part of the European colonies until the 1960s. In the early 20th century, European researchers such as Mauss and Durkheim (1903), Malinowski (1935), and Evans-Pritchard (1937) challenged the hierarchy of knowledge systems and societies induced by social evolutionism. Other authors, especially French surrealist anthropologists, ultimately discarded the socio-evolutionist approach. Ethnographers such as Rouch (1947), Griaule (1934) and Bataille (1929) deconstructed and questioned the concepts of normality, reality, and truth in the Western world. Rejecting the a-historical approach of Africa, European and African authors asserted the inclusion of the continent into global modernity (notably Balandier 1951, 1952): Africanist anthropology turned to a historical (Person 1971) and dynamist perspective to study social change (Grinker et al., 2019). Simultaneously, Marxism spread over the continent, finding a strong resonance among many authors – Senghor, Nkrumah, Cabral, Nyerere, Diop, Traoré, Nda, Rauche (Bidima 1995). In the 1960s and 1970s, Marxist anthropology, led by Meillassoux in Africa (1975), rose and focused particularly on the study of modes of production, the economy, the treatment of women and slavery. At the same period, Americanist anthropology, in connection with the contemporary political and economic history of the Americas, examined political processes and State formation, military regimes and democratization processes, urbanization and peasant classes, as well as environmental changes (Gruzinski & Bernand 1992).

With the 1960s and the beginning of decolonization processes, numerous authors challenged and questioned anthropology as a colonial science, producing a critique

of modernity and its system of knowledge (e.g., Latour & Woolgar 1979). As a result, new research themes emerged in Africanist anthropology, including mobility and displacement, urbanism, political violence, armed conflict, and new forms of belonging (Grinker et al. 2019). For its part, Americanist anthropology renewed its interest in indigenous communities, their ways of living and ritual practices. By the 1980s, the politicization of indigenous communities from the Americas gained momentum at national and international levels (Langdon 2016; Blaser 2014). Their ways of life and knowledge systems aligned with global ecological themes (Jackson & Warren 2005; Deléage 1991) and consequently, they progressively gained legitimacy and validity as models and viable solutions for environmental crisis management (Redford 1990; Chandler & Reid 2018). With this change of perspective, innovative anthropological currents and approaches developed in these new contexts, such as perspectivism (Eduardo Viveiros de Castro 2007, 2009) and the following ontological turn. Indeed, many anthropologists – among others, Latour (1991), Ingold (1996, 2006), Viveiros de Castro (2007, 2009), Descola (2005) – developed an ontological approach in the 1990s–2000s, inspired by postmodernism in anthropology and by the pre-eminence of issues around nature and the environment in the late-20th-century-globalized world. Their approach questioned the modern naturalist world's distinction between nature and culture and theorized the possibility of alternative, valid, and co-existing realities within human societies.

Infectious ontologies and medical epistemologies in Africa

While African philosophers relied on ontology in their work, including Kwasi Wiredu and Henry Odera Oruka (Bidima 1995), Africanist anthropologists rarely used the concept – with a few exceptions such as Fairhead 2016; Wilkinson & Fairhead 2017; Laplante 2014; Archambault 2020; Adji 2009; Thomas 1968; Mbiziantouari 2021. Contrary to Latin America, anthropology in Africa turned to political science in the 1980s (Copans 2007), focusing on the study of the organizational and operational modes of development (Olivier de Sardan 1995, 2001), healthcare (Jaffré & Olivier de Sardan 2003) and civil society (Comaroff & Comaroff 1999). Therefore, local contexts were not re-examined from an ontological perspective. The intent of an Africanist ontological approach is thus to reconsider well-known fieldwork from a new perspective and to deconstruct and challenge domination, power relations and hierarchies between different worlds and epistemologies – particularly between African contexts and the rest of the world. Therefore, the objective is not to import and impose the ontological approach as conceptualized by Americanist anthropologists, but to investigate African local realities from an ontological perspective. In a context of epidemic crisis and ontological frictions between the various actors from distinct worlds, it is thus necessary to question how structural contexts contribute to build local ontologies as much as they are shaped by them. To do so, I propose to revisit the history of medical epistemology in Africa in order to contextualize current practices of epidemic management in historical, geographical, political and ontological terms.

According to Bonnet (2003), conceptions of the body, health and ill(ness) – "illness" as well as "misfortune" in a broader sense – are the result of a long history in Africa, influenced by several philosophical and theoretical currents that have spread across the continent – such as Islam, Pasteurian theories, biomedicine, among others. Similarly, Western concepts of "health" and "disease" are the product of a long European – and later, Western – history. They have spread globally through colonization and globalization processes, being widely exported to other contexts. As Packard (2016) explains, global health interventions developed in the continuity of colonial medicine and outside of donor countries. It instituted and reinforced a hierarchy of health at global level, with Northern countries providing medical resources (material, funding and technologies) to the Global South. However, modern biomedical discourse is far from being a technological progress detached from any symbolic or ideological meaning (Bonnet 2003). On the contrary, it is a specific theory of social relations and being – as are local discourses of care and illness (Le Marcis 2003) – focusing on bacteria, microbes, viruses, parasites, etc. This ontological epistemology – in the sense that it defines existence, the world and beings that inhabit it – encounters other existing local worlds and results in a phenomenon in which actors negotiate daily to make sense of the world, illness, and the ways they can protect themselves from it.

Revisiting the Covid-19 pandemic from an ontological perspective

Negotiating with the invisible: Covid-19 in Guinea

Ms. Diallo left the mop against the wall and wiped her forehead before arranging her surgical mask on her mouth and nose. It was February 22, 2021, and I had been hospitalized for five days at Gbessia CT-Epi with a Covid-19 positive test but no symptoms. Outside the CT-Epi, the population was anxious as the government had announced the resurgence of the Ebola epidemic in the Forest region on February 14. Since I arrived, Ms. Diallo had refused to allow a hospital cleaner enter and clean the room: she moped and bleached the room herself daily.

> "I don't want them to clean here: they go into rooms with very sick patients and then they come here [to clean] with the same water. They come and re-contaminate us and this is how people end up staying here so long", she explained.

Moreover, since my arrival, she had been sharing pieces of advice and tips with me so that I can test negative and be able to leave the CT-Epi as soon as possible. According

to her, and to most patients on the asymptomatic wing, in order to get discharged, it was necessary to reduce one's viral load and to avoid "more" contamination. Thus, Ms. Diallo refused to hang her laundry in the CT-Epi courtyard. She sent it home to be washed and dried because "outside, laundry can get other germs and, after, you contaminate yourself with it". She washed her hands when she returned to our room and she prayed to God to heal us faster. Other patients rinsed their noses with herbal remedies or toothpaste before their Covid-19 testing, so "the virus does not stay in your nose". Ms. Diallo complained:

> "We are almost cured and they add a new patient [in the room] who comes with the disease. Doesn't it contaminate us again or make us last longer with the virus?"

All patients at the CT-Epi wore a surgical mask 24/7 in order to not increase their viral load with newcomers, but also to avoid other viruses such as tuberculosis. Some took the prescribed treatment while others prefered to have "traditional" medication[7] delivered to them.

At the CT-Epi, the interaction between patients and Covid-19 unfolds in a constant cohabitation with the virus, whose negative impacts must be managed. In this context, the "viral load" appears for the patients as a damaging residual imprint that increases after a contact with a dangerous entity – here, Covid-19 virus. Thus, the main objective of patients is to do everything in their power to reduce and eliminate this viral load in order to be discharged from the CT-Epi. To do so, they implement tactics of avoidance in relation to potential contaminant sources such as other patients, cleaning water, outside air, etc. These interactions are particularly challenging to manage as viral non-humans directly inhabit and cohabit with humans – here, the patients – and therefore these latter must be included within avoidance strategies. Managing viral risk thus involves a meticulous supervision of interactions between humans and non-humans – specifically viruses in the CT-Epi – and results through performativity in the crafting of strategies, practices, narratives, discourses, and behaviours that give life and substance to viral entities.

This is particularly visible in the linguistic designation of diseases and viruses, which are referred to as acting subjects: "Illness took me", "It is going to take you", "Corona came", "Corona did not work here so they called back his big brother Ebola" [interviews at Gbessia CT-Epi]. These acting subjects are not necessarily personified, but they acquire characteristics of acting non-humans with a potentially harmful agency and power for individuals. As other acting beings of this type – animals, genies, spirits, deities – some diseases are renamed with elliptical names or paraphrases in different local languages: diankaro noni or "dirty illness" for Covid-19 in Maninkakan, gnon gnonwo or "bad illness" for Ebola in Kpèlè. This conceptualization of viruses and germs as acting non-humans can also be ascribed to the (bio)medical world (Jaffré 2003), which shaped hospital hygiene according to a pathocenosis model (Grmek 1969) – a "community of diseases" or an ecosystem of diseases – that describes "hospital landscapes, so to speak, from the point of view of germs" (Jaffré 2003: 343). Germs – and especially viruses – constitute a part of the Western invisible world, exported at global level both physically through contaminations and epidemics and ontologically through biomedical discourses and health policies. They are beings whose interactions must be managed with caution and prevention in order to be protected from the dangers they represent. Integrating viruses from the European then Western biomedical world into Guinean society thus contributes to create an ecosystem of ontological repertoires (Fairhead 2016) that actors jointly mobilize in order to make sense of the world and to protect themselves from its dangers. Moreover, these viruses are incorporated in a local system of health and illness that is used to negotiate with the invisible – viruses and germs being now as harmful in Guinea as genies, witches, animals and other spirits.

Managing epidemic risk: medical syncretism, ontological repertoires and choreographies

Managing Covid-19 virus in the CT-Epi for patients involves taking medication, purifying oneself through cleansing (nose, throat) or ventilation, praying, eliminating the virus from the room and avoiding all potential contaminants. These practices constitute a protection against ill in its broadest sense – including illness and misfortune – rather than a targeted prevention against a specific disease. Thus, the biomedical concept of "contamination" does not cover the diversity of local conceptions of illness in a country where this latter can be transmitted not only through contact with a sick individual but also through deadly or impure contact (Bonnet 2003) – as it is the case in other African countries (Diallo 2003; Caprara 2000). If biomedicine is largely employed to cure diseases, the causes of diseases themselves are often attributed to other ontological repertoires (Wilkinson & Fairhead 2017): social misconducts, disregard of a taboo, wrath of a deceased person or spirit, spell cast by a witch (Zempléni 1985).

Protection against (ev)ill, broader than illness prevention, involves preventive and curative care coming from various repertoires: not only traditional medicine (self-medication, remedies, decoction of herbs) and biomedicine, but also practices in Islam, body and house cleanliness, respect of social rules, avoidance of morally impure behaviours, recourse to God. As Fairhead (2016:

7 Mainly herbal decoctions and remedies (for drinking or washing use) made by tradipracticiens or traditional doctors – refering to a medical epistemology previous to modern biomedicine.

12) explains, Guinean people draw extensively from the various ontological repertoires available to them in order to take care of themselves – even if these latter appear contradictory –, as long as they can combine them in practice: "… modes of practical coexistence have emerged in which any cultural (or ontological) incompatibilities are not relevant". Traditional, religious[8] and modern bio- medicines are thus means of action and resources conjointly used by Guinean actors in order to navigate daily life in the context of illness. This simultaneous coexistence of different ontological repertoires renders visible a syncretism of world views and beings – according to the risk they represent, in relation with illness. However, epidemic crises and the response models they entail constitute moments of disruption as they reduce actors' possibilities to recourse to this ontological syncretism to heal themselves and make sense of illness (Fairhead 2016). This can lead to resistance from local populations towards preventive measures and to a polarization of ontological discourses now defined in opposition – "biomedicine" versus "ethno-medicine". This phenomenon contributes to antagonize social identities as much as knowledge systems (Attas et al. 2021). Thus, during the 2014–2016 Ebola epidemic in Guinea, numerous rumours spread (Bannister-Tyrrell et al. 2015) and reluctance (Fribault 2015; Somparé 2020) and conflicts arose between the various proponents of these ontological repertoires. Processes of negotiation, translation and articulation of different ontological repertoires can be analysed in terms of ontological choreographies, that is, "a deftly balanced coming together of things that are generally considered parts of different ontological orders (part of nature, part of the self, part of society)" (Thompson 2005: 8). Le Marcis (2022) applies the concept of ontological choreographies to global health, epidemic preparedness and surveillance platforms. He explains:

> "The concept of choreography invites to examine how different ontological regimes conceptualize risk (Descola 2005), encounter, collaborate and/or generate friction within these platforms. […] Analysing "ontological choreographies" resulting from these encounters allows to question the conditions under which collaborations are possible between different worlds in the field of global health[9]".

Thus, analysing African worlds in these terms enables us to examine, not only how local actors mobilize different ontological repertoires to navigate daily life, but also how these different repertoires generate friction and produce complex ontological choreographies enabling the practical functioning of the lived world. Ontological theoretical tools highlight how, in the field of health, these choreographies are rendered visible through the appropriations, translations, transformations and reluctances that emerge from local actors' practices and discourses. This is especially true during epidemic times, and particularly Ebola and Covid-19 epidemic in Guinea, as they lead to the encounter of multiple ontological discourses resulting from the implementation into local contexts of formalized response models from national and global health organizations (Somparé 2020; Mbaye et al. 2017).

Conclusion

This article analyses the application of epidemic response models in Guinea during the Covid-19 epidemic and questions the visible divergences between these models and the actual practices of care and epidemic management observed in the field. It draws on and supports the interest of an Africanist ontological approach, especially in relation with epidemics, illness and care. In the Guinean context, defined by multiple ontological discourses in constant friction, this approach highlights how practical norms and the mobilization of different ontological repertoires by actors within these choreographies enable the practical functioning of the lived world. It allows to move away from the assumption of dysfunctional and failing African systems to provide a genuine perspective on the worlds in which these norms are relevant. Finally, it also emphasizes how viruses, as other acting non-humans, are ontologically crafted and how, through their physical and discursive circulation, they are transformed, translated, and appropriated by local contexts.

While much rhetoric predicted the sanitary collapse of Africa with the Covid-19 epidemic (Bonnet et al. 2021), the announced disaster did not occur. On the contrary, the pandemic contributed to challenge the assumption of failing healthcare systems in Africa in comparison to the difficulties encountered by developed countries on this subject. It allowed the continent to assert its expertise and knowledge in terms of epidemic management and therapeutic systems.

8 Religious medicine refers here to religious authorities or Koran specialists such as imams or karamoko who use the Koran for healing people (for example through the use of surahs as protective talisman or through nasi, a consecrated water mixed with the ink used to write specific surahs and drunk as medication).

9 Personal translation from the original French source: "La notion de chorégraphie invite à saisir comment différents régimes ontologiques pensent le risque (Descola 2005), entrent en contact, collaborent et/ou entrent en friction au sein de ces plateformes. […] Analyser les "chorégraphies ontologiques" qui résultent de ces rencontres permet d'interroger les conditions dans lesquelles les collaborations sont possibles entre différents mondes dans le domaine de la santé globale".

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