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- 1 The Covid-19 pandemic provides a new prism for studying knowledge production in the face of a (new) global disease. It questions the relevance of the global health regime in its favourite field of intervention: the so-called ‘developing countries’ of the so-called ‘Global South’, which are typically considered dependent on the ‘Global North’ and underprepared for health emergencies. By ‘global health’, this article refers to the health intervention regime that succeeded the ‘international public health’ regime centred on disease elimination programmes of nation-states and the World Health Organisation (WHO) that had developed from the 1940s. The global health regime is characterised by the importance of the market as a regulatory principle, public-private partnerships as a mode of intervention, and risk management and chronic disease control as its main objectives. It brings together a community of actors who have been developing, analysing, comparing and recommending strategies for managing health issues, particularly for ‘developing countries’, for the past three decades (Gaudillière *et al.*, 2020). Global health gives a central place to evidence-based decision-making and cost-benefit assessment (Adams & Biehl, 2016). These approaches extend and reinforce a particular relationship to the production of scientific knowledge. Global health privileges specific themes and approaches to the detriment of others, maintains asymmetries in the distribution of knowledge and imposes specific frameworks for thinking about the uncertainty of health issues. The global crisis of Covid-19 sheds new light on the contours of knowledge production and its relationship to ignorance in the field of global health.

- 2 This paper explores how, in a set of African and Asian countries and between March and September 2020,¹ the fight against Covid-19 drew on particular tools, knowledge, and intervention frameworks. It analyses the production of both ignorance and knowledge as part of Covid-19 ‘responses’ (to use the term found in many official documents). In the countries we took in consideration,² such responses occurred within frameworks that are not really, and sometimes not at all, the ones usually thought of by those who structure the global health regime. The pandemic is challenging the very notion of a ‘global’ health regime: the public responses we considered were characterised by a national, sometimes even nationalistic,³ approach. Responses were almost always steered from the highest levels of the State and materialised by the set up of exclusive emergency groups: the Covid-19 taskforces. Our ‘Global South’ countries, the privileged field of global health experimentation, did not appear very different from the ‘Global North’ countries in the governance structure of their initial responses to the pandemic. This challenges assumptions about the elements that are likely to generate appropriate responses to health crises. It also calls into question a global economy of knowledge production and expertise mostly directed from the ‘Global North’.
- 3 In the context of the Covid-19 pandemic, where the mobility of researchers and the availability of decision-makers for interviews are minimal, we mobilised three methodological approaches. First, we analysed documents and statements from actors in the Covid-19 response (technical documents, press releases, official social media accounts, governmental, intergovernmental, and civil society sites). Second, we drew on a network of informants with access to public policy-making spheres that fed into the University of Edinburgh’s *Covid-19 Governance Mapping Initiative*⁴ (whose data was publicly available). In this paper, we use data from fourteen countries with different political and health systems. Third, we built on the projects, field experiences, and strong collaborations of the authors who have continued to work and investigate the crisis throughout this period.
- 4 We mobilise many examples, but the Democratic Republic of Congo (DRC) and India will serve as the main illustrations for understanding the governance of the pandemic and the different strategies and measures for responding to health risks. Our analysis distinguishes between three main types of Covid-19 responses: the denial of the epidemic, the replication of foreign or past responses, and the ‘recycling’ of epidemic experiences. Each illustrates a particular relationship to ignorance. The last part of the paper looks at the actors and tools contributing to the production of ignorance about Covid-19 and, in particular, the emergency technical groups or taskforces. They centralise data, produce emergency expertise, and often bypass the democratic and technocratic institutions. We analyse the taskforces’ primary tool, epidemiological data, as a specific object for making and disseminating knowledge in the health field. By considering how data was collected, analysed, and used throughout the Covid-19 epidemic, we explore how data may also be an ingredient of the production of ignorance. Therefore, this article proposes to clarify the complex dynamics that link ignorance, knowledge, and uncertainty in pandemic management in a set of different Asian and African countries.

Ignorance in global health

- 5 In this first section, we explore the idea of ignorance in global health using different conceptual approaches. We seek to provide a brief description of the weight of global health in the production and conceptualisation of ignorance in health (Gross & McGoey, 2015). First, we consider the idea of *undone science*, which requires going back to the genealogy of global health and that of *strategic ignorance*. Secondly, we take up an approach specific to the world of global health, that of ‘disease X’.
- 6 Global health is an object in constant evolution. It is an intellectual and political framework encompassing some of the most significant transformations of international public health in the last 20 years. They include the escalation of the globalised, secure, and commodified nature of health (Macfarlane *et al.*, 2008); the reconfiguration of the flows of people, goods, knowledge, techniques, and models of health organisation (Falisse, 2019; Petryna, 2009); and the deterritorialisation of public health programmes that emancipate themselves from nation-states (Atlani-Duault & Vidal, 2013). As Mark Nichter explains, health becomes global ‘when health problems transcend national boundaries, can be influenced by circumstances or experiences in other countries, and call for collective responses’ (Nichter, 2008, p. 156).
- 7 The ideas of ‘health security’ and ‘biosecurity’ are central to global health (Lakoff & Collier, 2008). They seek to address the risks posed by global flows and often focus on particular infections –SARS, Avian Flu, HIV– or animal health (Fortané & Keck, 2015; Nguyen, 2009). Responses to these global threats are typically organised around vertical programmes, i.e. programmes focused on specific (infectious) diseases (Kerouedan, 2013). A form of prioritisation is carried out *de facto*: only certain diseases receive the attention and funding of (a growing number of) organisations with significant resources such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Bill and Melinda Gates Foundation, or the GAVI alliance for vaccination (Sridhar, 2012).
- 8 Another characteristic of global health is the important and growing role played by private actors. They have shaken health governance and the (health) knowledge economy through public-private partnerships that have become commonplace for international health agencies. The central role of private actors is also manifested in the ‘global’ private financing initiatives led by new philanthropists, such as the Gates Foundation, and ‘responsible’ capitalists who influence the global orientation of public health through investments (Guilbaud, 2015).
- 9 These three concurrent movements –globalisation, securitisation and privatisation– are all part of an approach to health based on efficiency and profitability. Ultimately, the transition from international health to global health is a set of organisational, economic, political and epistemological transformations.

Strategic Ignorance and *Undone Science*: Health Knowledge Production in the Global South

- 10 The systems that produce ignorance and knowledge are interlinked (Frickel & Edwards, 2014). It is, therefore, important to bear in mind that a complex and heterogeneous past has shaped the production of health-related scientific knowledge in the ‘Global

South'. This past was global well before the current concept of 'global health' emerged. In many ways, global health is simply a new mutation of what was previously called 'international health', and before that 'tropical medicine' or 'colonial medicine'. In this respect, it is the heir to colonial science, which is abundantly described as one of the most effective tools of social, political, and epistemic domination (Drayton, 2005). Colonial public medicine clearly defines which knowledge is valid and defines the colonised as ignorant, including of their own diseases. This lineage and the asymmetrical foundation of international public health are key for understanding contemporary issues, including the current debate on the decolonisation of global health. Indeed, health knowledge in so-called 'developing' countries is often constructed at a distance and by imitation, without necessarily making much room for local realities or local researchers (Abimbola & Pai, 2020). This bias in the production of knowledge on countries targeted by global health is reinforced by what Seye Abimbola (2019) calls the 'foreign gaze' and often the dependence of scientific research in the 'Global South' on external resources (which have a fundamental influence on the choice of research topics and methods). The tensions generated by this dependency are an emerging theme in the social studies of science and technology, particularly in Africa (Geissler, 2013). These studies show instrumentalisations and asymmetries that are complex and beyond a 'simple' 'subordinate' relationship between African researchers and their foreign colleagues.

- 11 The entry of global health, following other related fields, into a computational age has only exacerbated a tendency towards not doing certain types of research, and even forms of 'strategic ignorance' –i.e. deliberately not doing particular research. Data produced in the 'Global South' is analysed and valorised by researchers in the 'Global North' who have both the legitimacy to develop and use complex statistical tools and the computational resources to do so. For instance, a *Lancet* article modelling the importation of Covid-19 into Africa in March 2020 had only one researcher attached to an African laboratory out of thirteen authors (Gilbert *et al.*, 2020). The organisations carrying out the analysis and their funders often define the global health research agenda, formulate the hypotheses, validate the methods needed for the computational work, and control the channels for disseminating results (Lurton, 2020). The practitioners in charge of health policies in the 'Global South' find themselves forced to use this knowledge defined by distant actors who are sometimes unaware of their specific contexts' nuances and pressing issues.
- 12 The works of Lindsey McGoey on *strategic ignorance* and David Hess on *relative undone science* are helpful to understand how the global health regime influences health priorities and research in 'developing countries', while also ignoring certain issues (which may, nevertheless, be seen as crucial by both national professionals and civil society organisations). In general, global health has been described as encouraging the fragmentation, 'verticalisation', and 'technicisation' of practices and knowledge (we will return to these terms later). Global health schemes framed in exclusively technical –rather than political– terms have been accused of weakening national health governance and loosening the grip of health system managers. Dominique Kerouedan argues that global health priorities do not allow for local issues and needs to be taken into account, as the latter often lie outside worldly shared technical objectives (Kerouedan, 2013). Some researchers even argue that global health prioritises research and action on conditions threatening rich countries' investments (Ollila, 2005). Others

point to the ‘myopia’ of global health programmes which tend to focus on particular, often the same, conditions, leaving out diseases that affect thousands of people (Buse & Harmer, 2007), and sometimes even concentrate on diseases that are no longer a top priority for ‘developing countries’ (see, for instance, Lindsey McGoey’s work on polio eradication campaigns over the past decade; McGoey, 2015).

- 13 The current distribution of global health funds is typically targeted at specific issues, which does not favour a broad approach to strengthening public health systems and research in ‘developing countries’. The lack of coordination and harmonisation between programmes, presented by several analysts as one of the recurrent bad habits of global health, also contributes to producing knowledge that is not relevant to most local populations and actors. Several authors also describe the multiplication of ‘verticalised’ data systems collecting information separately on pathologies or health issues that affect the same populations and are managed by the same health systems. As Johanna Crane’s study of biomedical research on HIV in Africa or Julie Livingston’s ethnography of cancer in Botswana illustrate, state-of-the-art biomedical research or epidemiological surveillance structures coexist with struggling public health services that are unable to address the health needs of their populations (Crane, 2013; Livingston, 2012). This new health configuration offered by global health to ‘Global South’ countries makes new high-tech structures exist alongside decrepit hospitals (Lachenal, 2013). In short, the funding, methods, and themes of global health affect the very possibilities of health knowledge production in so-called ‘developing’ countries.
- 14 In the context of Covid-19, an emergency fraught with uncertainties, the risk is that the fragile and imperfect knowledge production structure we described becomes prone to the loosening of the standards of proof, particularly when faced with claims of effective technical solutions. The confidence in technical solutions, often defended by the ‘legitimate’ holders of technical competence, has, for instance, put at the core of Covid-19 responses tools such as mobile contact tracing applications that had never been tested or evaluated and were often poorly calibrated.

Acting on uncertainty and thinking about Covid when it does not exist yet

- 15 Reflections about the issues of undone science and ignorance are not new in global health, but they have grown in recent years. In particular, global health researchers and practitioners have come to develop their own universal framework for dealing with ignorance and uncertainty: ‘disease X’ (Simpson *et al.*, 2020). This biosafety paradigm was established by WHO in 2018 in the wake of the Ebola outbreak in West Africa and used to federate efforts to prevent and possibly combat a pandemic caused by a pathogen that is unknown, or at least not known to cause human disease. Disease X discussions soon led to an arsenal of public policies and preparedness measures, which are all part of contemporary developments in global health that some do not hesitate to describe as over-secure (Wenham, 2019). SARS-CoV-2, a known but unknown coronavirus family member, has been described as ‘Disease X’ (Jiang & Shi, 2020).
- 16 The concept of disease X encompasses a whole range of guidelines, tools and recommendations and has led to the construction of *preparedness* rankings that are very severe for low-income countries. Indeed, ignorance in the context of disease X is that of

a ‘known unknown’ to use the conceptual framework posed by Donald Rumsfeld (Rumsfeld, 2011). The idea is to hold on to certainties and theories about the potential nature of disease X. This reasoning is also applied to the public health systems that are supposed to contain a potential disease X and the tools that are put in place to assess them. The *Global Health Security Index* (GHSI) and the *Epidemic Preparedness Index* will thus rank countries according to their degree of preparedness for an ‘unknown but knowable’ pandemic, using variables that reflect experiences from past health crisis management (Oppenheim *et al.*, 2019).

- 17 The approach of these indexes and rankings is not without merit, but their usefulness proved limited, to say the least, in the case of the Covid-19 pandemic. Biosecurity and preparedness indexes are based on the idea of *prior* knowledge, refined by the test of facts. In the case of Covid-19, they effectively condemned countries that were struggling to contain yesterday’s diseases to be described as necessarily highly vulnerable to disease X. Of course, there is much to be learnt from past epidemics, but it is not certain that the indexes and ranking indicators accurately identify the elements that mattered in past epidemic episodes (a difficult and not necessarily quantifiable task). It is also not necessary that these elements are those that will matter in the future. The known and knowable parts of ‘disease X’ are, by definition, unknown until (and often long after) its onset. The misadventure of the GHSI, already described elsewhere (Abbey *et al.*, 2020; Aitken *et al.*, 2020), illustrates these limitations: the 2019 ranking is inversely correlated with Covid-19 mortality and morbidity statistics (in terms of the ranking, the best-prepared states were the United States and the United Kingdom, and in Africa it was South Africa, the country most affected by Covid-19 on the continent, that was considered the most prepared). The failure of the GHSI reveals the difficulty of the global health regime to think about uncertainty using frameworks different from those of the standard indicators of the robustness and functionality of health systems. It also reveals its difficulty to think about a far more radical form of uncertainty: ignorance. It is, therefore, perhaps not surprising that when the Covid-19 pandemic started –and with it the realisation that the known part was limited and the unknown part likely significant, the actual governance and response framework proved not to be quite, if at all, that which had been thought of by the GHSI and the global health regime.

Governing an ‘unknown but knowable’ pandemic

- 18 Around the world, the Covid-19 pandemic has given rise to a range of responses. Various research projects, such as the Oxford Covid-19 Government Response Tracker⁵ and CoronaNet,⁶ have tried to map these responses systematically: they reveal heterogeneous practices, depending on the country and sometimes even the region of the ‘Global South’ or the ‘Global North’. Even if these projects do not make it possible to differentiate between policy announcements and implementation easily, they clearly show that the management of the Covid-19 is, above all, a matter of national security where public freedom-limiting measures are taken in the name of public health. This is also, very clearly, what we observed in the countries we examined. As of 30 June 2020, some form of state of emergency had been introduced in at least 86 countries around the world.⁷

- 19 While this trend towards (bio)securitisation fits well within the general framework of global health, the very national management of the Covid-19 uncertainty is an aspect that may not please the champions of global health. As is often the case in the history of epidemics, Covid-19 is rhetorically presented as a foreign enemy and the approach regularly has nationalistic overtones (Kloet *et al.* , 2020). Regional and international organisations were struggling to establish themselves as a coordination mechanism, especially in the early months of the pandemic. For example, the African Union or the Southern African Development Community (SADC) only came to the forefront of the Covid-19 battlefield belatedly, trying to bring together and harmonise a diversity of practices rather than imposing a roadmap from the start. Similarly, international aid organisations, which were absolutely central to the Ebola response in West Africa (Tomori, 2015), have had a much more discreet, even marginal, place in the response to Covid-19 in the countries we studied. One hypothesis, which remains to be explored, is that expertise and resources were mobilised on the high-income countries affected first.
- 20 A second major feature of the governance of the Covid-19 response, and one that is equally important to consider in understanding how risk, uncertainty and ignorance are addressed, is the centralisation of decision-making in the hands of *taskforces*, the emergency technical groups dedicated to Covid-19. They are composed of national actors close to the head of State in most of the countries studied and develop approaches to replicating foreign or past responses and ‘recycling’ local epidemic experiences. We now describe these two approaches and a third which, by definition, does not involve a *taskforce*: the denial of the epidemic. Each reflects a different relationship to ignorance, by producing or not producing knowledge and by calling for a refusal or shift in the mobilisation of knowledge about the pandemic.

Denial

- 21 One possible attitude towards Covid-19 is denial. The cases of Burundi and Tanzania are the most emblematic in our sample (Falisse *et al.* , 2021). In both cases, it is clear that the virus circulated, and killed, even as the authorities denied the existence of a health problem called Covid-19. Tanzania documented the beginning of the pandemic: 21 deaths and 509 cases were recorded as of 14 May 2020. However, on 8 June, President Magufuli declared the country free of Covid-19 ‘due to the prayers of its citizens’. This declaration followed others minimising the health crisis, notably by extolling the virtues of traditional medicine and the unreliability of tests. On 4 May, Magufuli stated that ‘a papaya, a quail, and a goat’ had tested positive.⁸ The African Union’s statements expressing concerns did not change anything. In Burundi, President Nkurunziza immediately expressed doubts about the existence of the virus. Eighteen cases were confirmed between March and April, but the authorities did not deploy a specific plan. The WHO office on the ground was concerned about the situation and tried to put a response plan in place, but its leadership was expelled from the country on 15 May. As in Tanzania, the idea of divine protection was invoked. Elections were being held in both countries in 2020. They were important for the regimes in place and were probably not unrelated to the denial of the Covid-19, which could have disrupted their organisation. However, in Burundi, President Nkurunziza, who had left his place to his appointed successor, died on 8 June. The press release mentioned a ‘cardiac arrest’, but the symptoms, and the persistent rumour, pointed to Covid-19 (especially as the First

Lady had tested positive a few days before). A few weeks later, the country set up a 'Covid-19 coordination group', and the authorities spoke openly about the risks posed by the virus. A little less than ten months later, a very similar scenario played out in Tanzania, where the president finally acknowledged the danger of the virus before succumbing, a few weeks later, on 17 March 2021, officially to a heart problem. The opposition and civil society linked his death to Covid-19.

- 22 Burundi and Tanzania are the most obvious cases of denial in the countries we have reviewed, but forms of denial are found in other contexts too. In India, China's neighbour, denial was also the strategy used in the first instance. At the end of 2019, while Wuhan province was dealing with the onset of the Covid-19 pandemic, India was facing massive and violent uprisings against the Citizenship Act passed by its parliament, which was deemed anti-Muslim. The authorities seemed unconcerned about the virus and denied any possibility of local transmission, despite the first cases identified in January in Kerala. Until March, the Indian authorities produced communiqués stating that there was no community transmission of the virus and that only cases imported from abroad were to blame. Finally, after this phase of denial, the Prime Minister announced on 24 March, four hours before it came into effect, the full lockdown of the country for at least 21 days. This second phase illustrates a second strategy identified in several of our survey countries, the replication of foreign or historical measures (see next section).
- 23 The denial of Covid-19 is almost a caricature: an untruth is circulating. It is in many ways the opposite of ignorance or doubt. It is based on faith in divine authority or in the government's omnipotence. Ignorance about the effects of an unknown pathogen is replaced by the certainty of protection coming from a place where neither the principles of biomedical science nor the language of public health apply. It is important to see that in the case of Burundi and Tanzania, 'denial' serves clear political ends (which are not new): a positioning against Western countries and liberal democracies that serves as a rallying cry for the regimes in place. It is the inability of Western countries to deal with uncertainty and disease that is targeted in the Tanzanian, Burundian and Indian examples. But this form of 'strategic ignorance' of the Covid-19 problem is only tenable when doubt remains. As the Indian case shows, the field of ignorance does not remain stable during the period of denial, because the knowledge of the virus improves but also because the epidemic spreads throughout the country and soon becomes so present that denial is no longer possible.

Replication

- 24 In the countries of the 'Global South' we studied, but also in many countries of the 'Global North', public authorities often reproduced measures similar to those taken in countries already affected. Typically, these measures are drawn from the 'classic' and historical register of anti-epidemic measures, such as the emblematic lockdown. Lockdown does not, of course, appear with the Covid-19 pandemic, but the Wuhan experience brings the strategy back under the spotlight. Lockdown measures soon became a cornerstone of the response to Covid-19, replicated around the world. For example, India imposed a nationwide lockdown with a strict travel ban on 24 March, even though it had 500 cumulative cases and only one death from Covid (for a population of 1.352 billion) and had just begun its screening campaign.

- 25 Such ‘replication’ of the lockdown approach has, however, often not exactly produced the expected results –among others because the socio-political contexts are different between the ‘Global North’ and the ‘Global South’ but also between ‘Souths’, between epidemics, and between historical periods. In India, no movement was allowed in the country as of 25 March. The announcement led to major rushed migrations from the cities to the countryside. Migrant workers, day labourers, and often the poorest of the poor decided to return to their villages of origin. This tragic exodus is the most visible symptom of the Indian-style lockdown, which did nothing to flatten the trajectory of the epidemic. The flight caused by the rapid lockdown may even have contributed to the spread of the epidemic throughout the country. Six months later, India had still not reached its epidemic peak and had become the second country in terms of the total number of diagnosed cases (after the United States) and the fastest growing country in the world in absolute numbers, according to the WHO.
- 26 Replicating approaches from abroad or from the classical register of epidemic management is a default mode of managing ignorance of global health. In the face of uncertainty, the attitude is to cling to what is perceived as best known practice because it seems to have worked in another geographical and historical (and often epidemic) context. This strategy is part of a rational perspective, but it does not completely remove doubt; it is not necessarily fully based on relevant *evidence*. Covid-19 is not entirely ‘knowable’ or anticipatable in the short term, particularly in terms of its epidemiology. By mobilising the work on *undone science* and social movements (Hess, 2016), we focus in the rest of this article on the modalities of crisis management that allow or not the adaptation or questioning of these ‘good practices’ and ‘good models’. In the case of the Covid-19 pandemic, as we show in part three, decisions are taken by a small group, often close to power and socialised to global health (or at least to globalisation), making it more difficult to emancipate from known models.

Reactivating local strategies

- 27 A third approach, which is often less well documented, has been to develop a Covid-19 response based on management mechanisms initially developed to deal with other epidemics. Rather than deploying general crisis plans to mobilise resources, this is a reactivation or ‘recycling’ of local strategies and local institutions developed during previous health crises. From February 2020, Uganda started checking for Covid-19 using thermal scanners at airports and entry points, following a procedure developed in the fight against Ebola (a procedure which was still in place because of the epidemic in neighbouring DRC). Liberia did the same. In the DRC, the reactivation of the infrastructure put in place to fight Ebola is evident. Very quickly, a Covid-19 emergency team was organised around the General Secretariat of the Ministry of Health. This secretariat is headed by Professor Muyembe, a recognised specialist in the fight against pandemics and until then the director of the Technical Secretariat of the Multisectoral Technical Committee for the response to the Ebola Epidemic (ST/CMRE). The Covid-19 Technical Secretariat comprises many staff from the ST/CMRE, and its response plan for Covid-19 directly states that “recent experiences on [Ebola] epidemics will be capitalised upon”. The DRC built its initial system on existing structures and tools, and readapted them to the specificities gradually identified for the Covid-19 epidemic. Thus, the data collection and compilation tools initially used for the linelist of Covid-19

patients are those already used for Ebola patients. The daily situation report formats are, initially, inherited from these same sources.

- 28 In India, the State of Kerala has also implemented this strategy. Kerala was the first Indian State to report cases of Covid-19 and, from the start of the outbreak, deployed a massive testing and tracing policy. As its health minister has stated, the 2018 Nipah virus outbreak (with a case fatality rate of 40-70%) prepared Kerala for Covid-19⁹. Control teams comprising field medical staff and numerous government officials were rapidly deployed through ‘Nipah’ structures to monitor the virus’s progress. More than simply mobilising a health plan, this involved using structures originally set up to combat a particular epidemic (and initially modelled to meet its characteristics). Through contact tracing, Kerala could track nearly 90% of primary and secondary contacts, who were encouraged to isolate themselves at home or in hospital. By the end of November 2020, less than 2,000 people had died from Covid-19 in this state of 36 million people (where 100% of deaths are recorded).
- 29 In the case of the reactivation or ‘recycling’ strategy, the same biomedical rationality as in the ‘replication’ of solutions described above is deployed, but this time it is better contextualised. To a certain extent, it is a distancing from globalised health: the ‘recycling’ that takes place is not necessarily antithetical to the recognition of globalised elements in health, but, in the face of imminent danger, it foregrounds a solution based on past experiences and local competences. While it may be tempting to see this as a ‘good strategy’, it should be noted that the strategy does not allow to manage uncertainty fully; while the legacy of structures and operating procedures from past epidemics allows for the rapid deployment of contextualised solutions, it also carries their liabilities and is not fully adapted to an epidemic with different characteristics. In the case of the DRC, for example, the reach of the Covid-19 epidemic is much more geographically extensive than Ebola epidemics and requires solutions for data collection and reporting on a much larger scale. While a recycled system may allow for rapid deployment, it may also mean that decision-makers avoid a more specific analysis of the current problem. Reactivation is only an effective way of putting actors back in action and equipping them with tools whose main quality is their existence and familiarity for actors in the field. We will now study how these actors and tools manage, prolong and reproduce ignorance.

Actors of and tools for the production of ignorance

- 30 The national, even nationalistic, security approach to the pandemic response is often reflected in the composition of the emergency groups formed to lead the response. These are, in practice, centred on national bodies and reduce the number of actors and opinions –thereby perhaps limiting the scope for uncertainty and the possibility of divergent opinions. Ironically perhaps, this mechanism corresponds to a form of internationalised (and taught) crisis management inherited from Cold War military strategy: the *taskforce*, i.e. crisis management through a new temporary committee of experts focused on a particular problem rather than by permanent institutions. These taskforces, which are not always officially named taskforces, are very similar across our different case studies. Everywhere, they will grow as the preferred space for managing the response to risk. In only two cases out of the fifteen we analysed, the emergency group emanated out of a pre-existing institution.

Covid-19 taskforces and the politics of ignorance

- 31 In the taskforces whose composition we were able to analyse, we regularly find officials who are not typically working on health issues, such as people from the Ministry of Defence, Home Affairs, Tourism, the Environment or Education. This could be seen as a multidisciplinary approach to the pandemic, similar to the idea of a broad coalition of actors promoted by many in global health under the 'one health' model (i.e. an integrated, systemic and unified approach to public, animal and environmental health). However, the taskforces also reflect a certain narrowing of the decision-making space.
- 32 Indeed, the appointment of taskforce members is, in all the cases for which we found information, done through a process of co-optation at the complete discretion of the highest spheres of power. It was very difficult for us to understand who is involved in these taskforces, despite them being at the very heart of Covid-19 responses. Their composition seems to change, sometimes rapidly, and the list of members was public in just over half of the countries considered. Needless to say, it is also very difficult to have access to both the information used in these taskforces and the real scope of their prerogatives. The taskforces we have analysed often resemble the close guard of those in power. An interesting case is that of Malawi where the taskforce has become (slightly) more inclusive in response to court rulings that invalidated the harsh lockdown approach (following complaints from civil society).¹⁰
- 33 The creation of taskforces typically been accompanied by the marginalisation of actors once considered key in the management of epidemics. We have already mentioned the international health actors, UN agencies, and international NGOs, which have substantial influence on health policy in many low-income countries and have often been reduced to an operational support role in the pandemic response. In only one of the cases we studied, Sudan, did the WHO appear in the inner circle of decision-makers in the response. Marginalisation is not, however, limited to international actors. In several countries, our informants spoke of 'over-concentration' and our work and colleagues' (Rajan *et al.*, 2020) show taskforces that reflect, often to the extreme, power relations in the public space. They include men rather than women, people close to or very close to power rather than people critical of power, or, as our data on Somalia reveals, representatives of doctors' associations rather than nurses' associations. Military personnel are regularly present but in small numbers.
- 34 The taskforce has the trappings of cognitive diversity as a plurality of ministries are involved, but it is also marked by epistemic impoverishment: almost by definition, the taskforce policy-making tool, in health or other areas, is not conceived as a democratic council and often does not even pretend to be one. Cristian Timmermann (2020) used the words epistemic ignorance (in relation to Chile) because those who make decisions in response to Covid-19 are unable to fully put themselves in the shoes of vulnerable groups in society and are often not required to engage in discussion with them given the disconnection between taskforces and representative and democratic institutions. In many countries, taskforce responses have been criticised, for instance, for being particularly gender-insensitive (van Daalen *et al.*, 2020).
- 35 The concentration of power within the taskforce also allows for closer management of information by governments. In India, the taskforce relayed government information, and when it did not do so, the government did not hesitate to reconfigure or even

bypass it.¹¹ Government pressure or affinity can, of course, play a central role in the production of ignorance beyond taskforces. Indeed, putting pressure on the media and scientists to control the dissemination of information on the pandemic was a central form of crisis management in India. Just before the lockdown, Prime Minister Narendra Modi (who usually never gives press conferences) summoned the heads of India's largest media outlets to warn them against spreading 'pessimism' and 'rumours' through negative news about the epidemic and urged them to 'reassure the Indian people'.¹² Similar pressure has been put on several scientific and professional organisations in India.

- 36 The use of taskforces will likely have long-term consequences for health system organisations. In the DRC, the Ebola and later Covid-19 Technical Secretariat mentioned above is, in a way, bypassing the Epidemiological Surveillance unit (DSE) of the Ministry of Health. In the long term, the 'routine' health system will have to deal with the management of Covid-19. Its actors will require Covid-19 management tools to do their work. However, the technical choices made on an *ad hoc* basis sometimes make it difficult to consolidate the decision-making systems and knowledge structures used routinely (even within the same ministry). This form of taskforce's 'toll' on routine health activities is particularly delicate when building key infrastructures such as data systems.

Centrality and reliability of data infrastructures

- 37 To justify their decisions, taskforces rely heavily on quantitative data, which is the currency of credibility in global health. The Covid-19 pandemic presents a major challenge in terms of producing figures to understand the epidemic. The verticalisation of health systems in 'Global South' countries has been accompanied by a substantial verticalisation of their health information systems. Often, they ended up being atomised into thematic subsystems using different reporting tools and different technologies (Kawonga *et al.*, 2012). As a result, relying on a pre-existing data collection infrastructure in which Covid-19 documentation would fit into an arsenal of pre-existing tools has rarely been possible. In systems where data for different conditions or services are collected in independent silos, adding a new condition requires constructing almost entirely new infrastructure.
- 38 The scale and complexity of the Covid-19 epidemic highlighted the need to de-segment data systems in order to understand the outbreak and organise the response. In the DRC, for example, creating a map of equipment that could be used to test for Covid-19 required data to be obtained from numerous state actors, NGOs, bilateral cooperation agencies and international organisations. Their compilation and the necessary consolidation of the different geographical reference systems used by these multiple actors underlined the difficulty of providing a unified and consolidated vision of the national health system. This is despite each actor's substantial investments over the years in their own data (systems). Such consolidation is harder in a crisis when new actors such as taskforces complicate the task of coordinating actors and weaken routine systems. At the beginning of the epidemic in DRC, the actors of response set up data collection subsystems to meet the specific needs of the actors on the ground. Some of these tools were the result of the reactivation and recycling of other systems, such as those used in the response to Ebola epidemics: the border police monitored screening

and quarantine of travellers, the laboratory responsible for screening ensured the feedback of test results, and the community health and hospital management teams recorded the patients and the outcome of their illness. In consolidating data systems involving diverse actors, the technical issues were complicated because different subsystems depended on different sources of funding, with different agendas and accountabilities. Competing applications are still in circulation to this day to collect the same information, linked to different 'partners' supporting certain actors or specific areas of the country.

- 39 The example of the DRC shows that, although data collection tools are available, the fragmentation of health systems caused by multiple and uncoordinated programmes and partnerships makes it challenging to combine and use them. Moreover, the tropism of the global health field for technological solutions that are supposed to provide quick answers to complex problems reinforces this fragility. In the past two decades countless generations of health information data systems have appeared, based on SMS and then on tablets, as well as data systems for monitoring patients in hospitals supposed to offer rapid solutions to the complex problems faced by low-resource countries (Read *et al.*, 2016). In times of crisis, some actors propose new tools, feeding this myth of quick fixes, when their tools are described as flawless is often only because they have never been tested in real conditions. The mirage of mobile tracking applications promised everywhere and rarely implemented is a good example (Al Dahdah & Alam, 2020). These solutions have the perverse effect of concentrating attention, resources and expectations in a single object, limiting the investment made in other smaller but more feasible projects. The exact extent of this crowding-out effect is by nature difficult to document and assess. Still, we can see, a year after the announcement of the start of their development, the lack of tangible existence of multiple applications presented as the centrepieces of winning strategies to fight Covid-19. These investments in uncertain technological solutions come at the expense of consolidating infrastructures that produce understandable and robust data at lower levels. The failure of health data infrastructures has been seen as far afield as the United States, where the initial inability of the *Centre for Disease Control* (CDC) to produce data at the national level was primarily overcome by citizens working together on a voluntary basis to obtain and compile data from local authorities. Simon¹³ notes that the main problems with this effort were transparency and the definitions used rather than technical.
- 40 The Covid-19 crisis has revealed how the very infrastructures of global health data are constructed to produce ignorance. On the one hand, the fragmentation of health systems and their verticalisation into programmes and themes make it difficult to produce unified visions of health issues on a national scale. On the other hand, the technicist temptation encourages solutions that are often not robust: they do not help build consolidated infrastructures, which would, for instance, mean investing in standards or norms allowing the exchange and effective use of data. In times of crisis, the technicist temptation central to global health has led to an additional technological risk being added to the uncertainty of epidemiological management; the use of innovative but poorly tested solutions contributed to the ignorance in which decision-makers found themselves when implementing responses. This section concludes with a discussion of the different ways in which epidemiological data and scientific knowledge

about Covid-19 can be misused and how their manipulation can serve ‘misleading optimism’ at the top of government.

Fetishisation and manipulation of data

- 41 At the end of September 2020, the *Lancet*¹⁴ editorial on the management of the pandemic in India alerted the public to the dangers of misleadingly optimistic information and data on the epidemic in India. The article, among others, questioned the transparency of data on cases and deaths from Covid-19, particularly those underlying case fatality rates. The Indian government reports a case fatality rate of 1.8%, which was much lower than the rate reported in other countries. Several reasons have been put forward for this low rate. The age of the population, the BCG vaccine used against TB or the high heat have been linked by some studies to low mortality rates from Covid-19. India has a lower proportion of older people than many other countries. However, other factors complicate this picture: for instance, its hospitals, overcrowded with many patients with comorbidities (e.g. undernutrition, tuberculosis, diabetes, chronic respiratory and cardiovascular diseases) could have added to Covid-19 mortality. More importantly, the reliability of the data on which these figures are based was questioned.
- 42 The uneven registration of deaths across the country was quickly identified as responsible for the under-reporting of Covid-19 mortality in India. Only 22% of deaths were medically certified in India, and certification was virtually non-existent in the poorer northern states, India’s most populous. By the end of September 2020, more than 65% of the total Covid-19 deaths reported in India came from just four states (Maharashtra, Tamil Nadu, Karnataka, Delhi) where there was 100% death registration. And even in these states, which have better death registration, patient were not systematically tested at the hospital. Those who died were also not necessarily counted in the Covid-19 lists because of comorbidities or because they died before being formally registered at the hospital. Tamil Nadu, for instance, added a few hundred ‘missed’ deaths to its death toll. So did Maharashtra. Like many other states, West Bengal had taken to exclude all deaths due to comorbidities from Covid-19 deaths (Chatterjee, 2020). Finally, the government was accused of failing to report figures reported by hospitals. In Delhi, for example, in April 2020 the government announced 15 times fewer Covid-19 deaths than were actually reported by Delhi hospitals.¹⁵ This points to the wider issue of manipulating scientific data and information in the management of the pandemic.
- 43 The highest governing body of the epidemic in India, the Indian Council of Medical Research (ICMR) has been singled out, by the *Lancet*, among others, for straying from the scientific evidence, appearing at best overly optimistic and at worst politically motivated. While both hope and recognition of progress are essential during this pandemic, the ICMT –which is close to the government– has been accused of presenting the Indian situation in an overly positive light, not only by obscuring the scientific reality of the epidemic but more importantly by preventing the implementation of essential public health measures. For example, the ICMR maintained until April 2020 that there was no “community” (i.e. local) transmission of the virus in India, which considerably limited the country’s testing policy, even though the first cases had been identified in Kerala as early as January. Despite insufficient scientific evidence, the

ICMR recommended the use of hydroxychloroquine as ‘preventive treatment’ for people who had been in contact with confirmed cases, either at home or in hospital, resulting in the uncontrolled use of a drug with possible side effects and, according to some reports, the death of several Indian health professionals who followed this recommendation.¹⁶ Several press reports allege that data on the infection was removed from scientific documents on the orders of the ICMR director¹⁷. Finally, scientists denounced the ‘speculation’ on herd immunity promoted by the ICMR. Surveys conducted in the summer of 2020 in Mumbai, Delhi, and Pune claimed that more than 50% of the population had already been infected, and would therefore be immune. This claim, however, had no scientific validity, since the threshold for herd immunity was unknown, and so was the duration of immunity after a person had recovered (Chandrashekhar, 2020)

- 44 India has the expertise in medicine, public health, research and biomedical production to help the country through the pandemic. However, the production of ignorance and organised misinformation –with unrealistic and unfounded official statements at the top of the State– created a widespread climate of uncertainty that discouraged Indians from taking public health messages and preventive measures seriously.

Conclusion

- 45 In our study of African and Asian countries, the management of Covid-19 and its uncertainties followed a set of strategic lines. They include the denial of the problem, the concentration of decision-making around a fairly small core of experts, the reproduction of tools from other contexts (such as general lockdown measures), and the ‘recycling’ of past epidemic experiences (Ebola in the DRC or Nipah in India). These solutions often implicitly reflect global health frameworks and power structures and reproduce forms of ignorance. Our findings are, however, unlikely to be specific to global health’s favourite testing ground: the ‘Global South’. Many of the aspects we have developed are also found in France, the United States, or the United Kingdom, leading to the same confusion and sometimes mistrust of citizens regarding their government’s ability to manage the pandemic. The often arbitrary and artificial separation between so-called ‘developed’ and ‘developing’ countries is also undermined, as the failure of the Global Health Security Index shows.
- 46 Ultimately, there is hope that the current crisis in global health may lead to improvements. In the absence of a satisfactory crisis management model that fits the global health power system, many critical actors are calling for a shift towards a more localised management of uncertainty. Accordingly, they push towards innovations, arrangements, and tinkering to solve concrete problems and bring about diverse solutions that strengthen the anti-pandemic arsenal. The hope is that the global Covid-19 crisis at least serves to build local and robust knowledge infrastructures, capable of reducing the asymmetry governing the production of global health knowledge, to reduce the uncertainty faced by health officials in the so-called ‘Global South’ or ‘resource-limited’ countries confronted with the Covid-19 pandemic.

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NOTES

1. This article was written at the end of 2020, it cannot take into account subsequent events and developments.
2. Burundi, Cameroon, Central African Republic, Chad, Republic of Congo, DRC, Egypt, Ethiopia, Gabon, India, Kenya, Malawi, Mauritius, South Sudan, Sudan, Uganda, South Africa
3. As such, the lack of solidarity and the almost complete disinterest of rich countries in making immunisation available in the 'South' is one of the most acute symptoms of the crisis into which COVID-19 has plunged the 'global health' community. <https://aoc.media/opinion/2021/03/08/vaccins-le-grand-emparement/>, accessed on 8 March 2021
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ABSTRACTS

The Covid-19 pandemic provides a novel opportunity to study the production of knowledge in the face of an 'unknown but knowable' global disease, particularly in the settings favored by 'global health' interventions: the so-called developing countries. This article focuses on the responses of fifteen African and Asian countries (with particular attention to India and the DRC). These responses fall into three broad categories, which in its own way produces ignorance: denial of the existence of the virus, replication of foreign or historical measures, and 'recycling' of local experiences. We also document the specific actors and tools that contribute to the production of ignorance about Covid-19, notably the construction and mobilisation of health data and the 'Covid-19 taskforces', the emergency groups that constitute the forum for disseminating knowledge and/or producing ignorance about the pandemic.

La pandémie de Covid-19 constitue un prisme inédit pour l'étude de la production de connaissances face à une maladie globale « inconnue mais connaissable », en particulier dans les contextes d'intervention privilégiés de la « santé globale », les pays dits « des Suds ». Cet article se concentre sur les réponses de quinze pays africains et asiatiques (en portant une attention particulière à l'Inde et à la RDC). Ces réponses rentrent dans trois grandes catégories qui sont, chacune à leur façon, productrices d'ignorance : le déni de l'existence du virus, la reproduction de mesures étrangères ou historiques, et le « recyclage » d'expériences locales. Nous documentons également les acteurs et les outils précis qui contribuent à la production d'ignorance sur la Covid-19, notamment la construction et la mobilisation des données de santé et les « Covid-19 taskforces », ces groupes d'urgence qui constituent l'instance de diffusion des connaissances et/ou de production de l'ignorance sur la pandémie.

La pandemia del Covid-19 proporciona un lente novedoso a través del cual estudiar la producción de conocimiento ante una enfermedad «desconocida pero conocible», particularmente en los contextos predilectos de intervención de la «salud global»: los llamados países del Sur Global. Este artículo se enfoca en las respuestas de quince países africanos y asiáticos (con especial atención a India y la RDC). Estas respuestas se dividen en tres categorías amplias, cada una de las cuales produce, a su manera, ignorancia: negación de la existencia del virus, reproducción de medidas extranjeras o históricas, y «reciclaje» de experiencias locales. También documentamos a los actores y las herramientas específicas que contribuyen a la producción de ignorancia sobre el

Covid-19, en particular la construcción y movilización de datos de salud y los «task force del Covid-19», los grupos de emergencia que constituyen el foro de difusión de conocimiento y/o de producción de ignorancia sobre la pandemia.

INDEX

Palabras claves: ignorancia, ciencia no hecha, diversidad cognitiva, epidemiología, salud pública, salud global, Covid-19, Sur Global, India, RDC

Keywords: ignorance, undone science, cognitive diversity, epidemiology, public health, global health, Covid-19, Global South, India, DRC

Mots-clés: ignorance, science non faite, diversité cognitive, épidémiologie, santé publique, santé globale, Covid-19, Suds, Inde, RDC

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