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## **COVID-19 and Colonial Legacies in West Africa**

Kalala J. Ngalamulume

Over the past three years, the outbreak and worldwide spread of the COVID-19 operated as a mirror showing societies to itself, with its division along racial/ethnic, class, and gender lines. The pandemic generated particular anxiety concerning Africa. Doubts over the ability of most African states to contain it led to the predictions of a viral tsunami on the continent.

Such dire warnings were based on the assumption that poverty, underdevelopment, corruption, and underfunded and poorly maintained health care systems would allow the virus to overwhelm the capacity of African governments to respond. But that did not happen. In part, this outcome was due to the demographic structure of the continent, dominated by a large youth population, as well as previous experience with epidemics.

In West Africa, the COVID-19 experience has had some notable continuities with past epidemics, including yellow fever, bubonic plague, and Ebola. Among these continuities are the legacies of colonial medical practices, the uncertainty of the medical authorities in the face of the emergence and high transmissibility of evolving pathogens, and the initial lack of knowledge on transmission routes. The widespread unpreparedness of health care systems has been another constant.

Colonial legacies are visible in the ways in which epidemics and pandemics are constructed or framed, not just as medical events, but also as political events. The very decision to declare a medical emergency is a political act, often reflecting structures, policies, ideologies, and practices from the past that bear on the present, sometimes resulting in unintended consequences.

In the cases of yellow fever and bubonic plague epidemics of the nineteenth and early twentieth centuries, the evidence suggests that what began as medical or biological events became major social and urban problems. Today, such colonial patterns can be discerned in the inadequacy of medical infrastructure and personnel and their unequal distribution between cities and the countryside.

Another colonial legacy was the disempowerment of the African healers. They were banned and whose medical practice was labeled as superstition. Given that almost 80 percent of the present rural population lacks access to biomedicine because of either the cost or the geographical distance to facilities, turning to the health services provided by healers becomes unavoidable. This factor played an important role in the COVID-19 pandemic.

## **PANIC AND HYSTERIA**

In the colonial era epidemics, high mortality rates among the European population provoked moral panic and racial hysteria. Colonial administrators and medical authorities associated the black urban presence with the slums and disease.

In Saint-Louis, Senegal, yellow fever epidemics led the colonial authorities to adopt a policy of residential segregation that resulted in the forced removal of the urban poor from the city-island and their relocation in the periphery. In British Sierra Leone, malaria provided the most important single argument for sanitary segregation. European residents were evacuated from the African section of Freetown and relocated to the newly erected Hill Station in 1902.

Similarly, the 1914 epidemic of bubonic plague in Dakar helped accelerate the policy of segregation that had started a decade earlier in response to a series of yellow fever epidemics in the late nineteenth century. The forced removal from the city of thousands of workers would have provoked disruption in the labor supply. And the sanitary emergency was declared three days after the elections that resulted in the victory of Blaise Diagne, the first black citizen to represent Senegal in the French parliament. The people targeted for the forced removal were his voters. The policy was only partially implemented, due to these economic and political constraints, but still left a legacy of mistrust among the urban poor.

Another example of continuity between past and present in West Africa had its origins in colonial doctors' role in conceptualization of Senegambia as a tropical region, meaning a diseased space. This led in the construction of the difference between metropole and colony; colonizer and colonized. It was in this context that yellow fever was framed as the white man's disease (because of high mortality observed among the Europeans and the perception that the black population had acquired natural immunity since childhood), and cholera as the black man's disease.

Doctors also contributed to the production of materials for understanding the black Africans whom the French authorities referred to as indigènes, including claims about their supposed mentality, lifestyle, hygiene, and role in disease production. In the process, doctors helped construct hegemony through various biopolitical interventions against suspected carriers of pathogens and the mentally ill. These interventions included a registration system, managed by the municipal police, for single women who had to be screened every month for the detection of sexually transmitted diseases; a project, eventually abandoned, to open a licensed brothel; and smallpox vaccination. the insane; the use of eye surgery, smallpox vaccination.

The construction of Africa as a dangerous tropical environment - a diseased continent - has endured. This form of Afrophobia has been evident in the COVID-19 pandemic. Consider the isolation measures imposed in late 2021 by the United States and other nations on eight

southern African countries suspected of having high prevalence of the highly transmissible Omicron variant. The United State and Europe ended up having what appeared to be much worse Omicron case surges than these African countries.

Global health initiatives to combat epidemics and pandemics have worked through colonial infrastructures and colonial imaginings. These initiatives have often had unintended consequences due to their failure to take account of realities that do not fit their assumptions. During the period of colonial rule, the enforcement of disease-control measures, such as quarantines and cordons sanitaires, generated a conflict of interests between public health, commerce, and civil liberties. French merchants in Senegambia protested the long delays caused by the sanitary inspection of ships and the fumigation of merchandises.

In the COVID-19 pandemic, most African governments adopted policies that did not account for scarce resources, the political capacity to enforce them, or living conditions in crowded cities. The policies included declarations of emergencies, curfews, school closings, anti-disinformation campaigns, promotion of hygiene measures such as social distancing, movement restrictions, internal border restrictions, bans on gatherings, and testing and tracing programs.

These measures were gradually abandoned as mortality rates turned out to be low, and in response to popular protests. Most of the urban poor who live with one dollar a day rejected the movement restrictions imposed upon them by the state. Mask wearing and vaccine mandates became another source of contention.

Unsettled by rumors about the ineffectiveness of the available vaccines, many people turned to traditional health practitioners, who continue to have a huge following in most cities. Public markets in Dakar have sections devoted to the sale of medicinal plants, and the number of visitors seeking herbal treatments and traditional remedies has drastically increased since COVID-19 struck. Government officials in Madagascar promoted an herbal tea called COVID-ORGANICS, made from the medicinal plant artemisia, already used in treating malaria.

In West Africa, popular mistrust in the state and its biomedical interventions can be recognized as a legacy of the colonial era, when disease control measures served larger agendas of controlling and segregating the black population. The depiction of Africa as a dangerous, unsanitary tropical zone of contagious diseases that threaten richer parts of the world is another unfortunate colonial legacy that resurfaces in global health emergencies. It is necessary to understand the origins of these views in order to address them effectively. Learning from history can help us better prepare for future pandemics and open a path to more equitable public health measures and outcomes in West Africa and beyond.