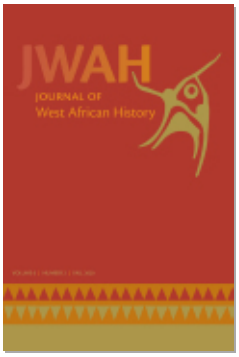
COVID-19 and Caution for Historians: Views from a Place in West Africa



Kwasi Konadu

Journal of West African History, Volume 6, Number 2, Fall 2020, pp. 115-125 (Article)

Published by Michigan State University Press

COVID-19 and Caution for Historians:

Views from a Place in West Africa

KWASI KONADU
Colgate University

ABSTRACT Using the West African nation of Ghana as an angle to size up the moving target of COVID-19, I want to suggest some dangers in how we approach the pandemic in the lives of West Africans and in the broader African world. Covid-19 is both global and local, and so our perspectives must be attentive to global patterns and local consequences and responses. In tandem, these form the base ingredients for any future history of Covid-19 in African societies as well as around the global, for Africans are amongst the most mobile, most globalizing of all peoples.

RÉSUMÉ En utilisant la nation ouest-africaine du Ghana comme angle pour évaluer la cible mouvante de COVID-19, je veux suggérer quelques dangers dans la façon dont nous abordons la pandémie dans la vie des Africains de l'Ouest et dans le monde africain en général. Covid-19 est à la fois mondial et local, et donc nos perspectives doivent être attentives aux modèles mondiaux et aux conséquences et réponses locales. En tandem, ceux-ci forment les ingrédients de base de toute histoire future de COVID-19 dans les sociétés africaines ainsi que dans le monde, car les Africains sont parmi les plus mobiles et les plus globalisants de tous les peuples.

No one writes human history as an interpretation of sources when its unit of analysis, human action, is an evolving phenomenon without closure. A raging pandemic sits as a thick fog clung to the earth, blanketing almost everything, including this forum, a special issue of the *Journal for West African History*. COVID-19 envelops, and it seems getting sucked into thinking about Africa through the optics of the pandemic is unavoidable. And yet, whatever its gravitational pull, it is precisely because there is no terminal marker, as when the World Health Organization (WHO) declared the end of the H1N1 influenza pandemic in August 2010, historians of Africa and elsewhere are in no position to utter that COVID-19 has significantly affected the course of human history. All that we will do and say is contingent upon what happens next, and what constitutes next may or may not change how much COVID-19 is a significant turning point in the long-term histories of Africa and the globe. Instead, we might benefit from tempering our pronouncements with searing questions and cautions about comparisons. How will this pandemic affect academic institutions, knowledge, and the producers and consumers of textbook-supplied facts? What will be COVID-19's consequences for social and political transformation? How far do we take analogies, in that COVID-19 is a *war* against humanity, or in drawing comparisons, in that the pandemic shares striking parallels with the influenza pandemic of 1918–19? The shape of these questions and the contents or artifacts produced from COVID-19 to mull over will have to wait. Short of any full assessment, however, we can make some tentative observations, and using the West African nation of Ghana as an angle to size up the moving target of COVID-19, I want to suggest some dangers in how we approach the pandemic in the lives of West Africans and in the broader African world. COVID-19 is both global and local, and so our perspectives must be attentive to global patterns and local consequences and responses. In tandem, these form the base ingredients for any future history of COVID-19 in African societies as well as around the globe, for Africans are amongst the most mobile, most globalizing of all peoples.

In the global age of COVID-19, analogies of war and comparisons to other pandemics have renewed interest in the influenza pandemic of 1918–19. Naturally, an emergent pandemic at the tail end of a world war offers an approximate source. Until recently, World War I (c. 1914–18) greatly overshadowed the pandemic of 1918–19, though the scourge of influenza infected half a billion and killed twice the number of soldiers in combat and more than all the soldiers and citizens who died in the war. Though people die in war as combatants and unintended casualties, war is a product of human agency. The causes and consequences of war are not located in nature nor a laboratory or a market of human–animal proximity, where diseases jump from one specie to another. COVID-19 is different from war; it is an event because the world knows about it and the response is global.

COVID-19 is also unlike other iterations of influenza. But war and pandemics share an elongated moment, for World War I was connected to the pandemic of 1918–19 through the auspices of colonial rule, mobilization, and the commercial cannibalization of labor and land.[1]

In sub-Saharan Africa, the pandemic of 1918–19 accounted for 1.5–2 million deaths, adding to the plunder and carnage that accompanied European wars of conquest and staunch African counterresistance.[2] European slavers-turned-imperialists used private companies to pillage newly conquered territories. These agents of conquest violently opened up ecologies to contagions and death, created ports and transportation routes to move valued resources swiftly out of colonies, used forced labor indistinguishable from slave labor, and dispossessed indigenes of land while conscripting occupants into a cash (crop) economy through taxation schemes. Leopold II's ironically named Congo Free State is but one of many telling examples, where the pursuit of wild rubber for export killed some 10 million African women, men, and children, and mutilated countless others between 1880 and 1920.[3] Densely packed forced labor camps, migrants and refugees forced to be mobile, and colonial penetration and its transportation networks in the Congo basin were at the heart of diffusing another, far more deadly disease in HIV/AIDS.[4] In the Congo and elsewhere, everyday violence—another kind of existential war—forced Africans to provide colonists with front-line troops, porters and laborers, and food and raw materials, subsidizing the World War I campaigns. Hundreds of thousands died from combat, but even more from the corollary effect of disease and malnutrition. The largest imperialists in Africa, France and Britain, used the War and the effects of the pandemic of 1918–19 to consummate their colonial conquests.

For the tripartite Gold Coast colony—divided as it was into the Gold Coast Colony, Crown Colony of Ashanti, and the Northern Territories—more than 100,000 in an estimated population of 2.3 million were killed in fewer than six months by the influenza pandemic of 1918–19. These colonial holdings were administered, resourced, and caricatured differently through the machinations of imperial Britain and these inequities on the ground shaped the course of the pandemic throughout the colony.[5] The issue was not that influenza was new; the Gold Coast was visited by an influenza pandemic in the early 1890s, at a time when "the large majority still resort to the 'Native Medicine Man'" in spite of hospitals, rural clinics, nursing corps, and improved sanitation in major towns, in particular where Europeans resided.[6] What was at issue was the uneven distribution and toll of the 1918–19 pandemic, which aggravated an already troublesome set of diseases: malaria, yellow fever, smallpox, and sleeping sickness. The pandemic terrorized the northern regions, which shouldered most of the fatalities in the tripartite colony, though the disease was introduced from the ports on the coast *and* from the

French colonized territories still further north. New colonial roads opened the northern savanna country to the densely forested south, allowing northern migrant laborers to flood the southern reaches of the cocoa exporting colony through crossroad towns like Takyiman.[7] Peoples moving back-and-forth with the pandemic to their scattered villages in the north rightfully wondered, "if this is the end of the world."[8] As migrant laborers, these northerners were tethered to the cocoa extraction industry that financed the prosperity of the tripartite colony, and thus the process of creating the colony's extractive infrastructure and getting colonial subjects of the British empire to "buy in" was no clearer than in the north.

At the end of the nineteenth century, colonial government stores were established in the northern districts "to give the people a taste for articles of merchandise, and also to accustom them to the use of money as the medium of exchange and to pave the way for the establishment of trading houses by mercantile firms." This "successful experiment" was preceded by military force, occupation, and treaties, but strategically followed up by mission schools and government officials to manage the territory.[9] Though the Northern Territories had the fewest mission schools, perhaps owing to the varied presence of Islam and indigenous spiritualities, it was the least resourced—"not an integral part of His Majesty's dominions"—and thus the hardest hit by the epidemic.[10] Locally dubbed "Africa," the epidemic swept through the tripartite colony in 1918–19. In the previous year, fear that an outbreak of smallpox might spread to Takyiman, the largest market town between the north and the south, was a harbinger of things to come. The district commissioner requested Takyiman's ruler to keep "a sharp look out for any strangers who may arrive in your villages with this disease. If any cases arise they should at once be placed in a hut outside the town and looked after by those persons who have already had small pox, and the matter reported to me immediately."[11] Whatever the effect of this strategy, such measures had mixed results against influenza. In the outlying Takyiman village of Asueyi, villagers recalled the Tanɔ *ɔbosom* Twumpoduo protected them from the influenza epidemic; Twumpoduo was thanked with two sheep and bottles of schnapps.[12] Others, such as *ɔbosomfoɔ* Kwasi Badu, who became a healer during the epidemic, died from the disease.[13] Overall, the records suggest preventative action and quarantine were futile and both African therapeutics and European biomedicine only alleviated symptoms.

The spread and consequences of the pandemic and the anemic measures marshalled to control it in the Gold Coast was similar to other African colonies, in fact much of the world, but there are limits to comparisons between earlier pandemics and COVID-19. The great (Justinian) plague of the sixth century, originating in Central Asia and carried along land and sea routes, killed millions, sharing the same pathogen, the bacterium *Yersinia pestis*, as the fourteenth-century bubonic

plague. Though viruses are smaller than bacteria, there is a big difference between them, and between these plagues and the influenza pandemics of 1918–19 and 2020. Viruses like influenza need a host in order to survive, unlike bacteria. The bubonic plague morphed into a series of local and regional epidemics, hanging around for centuries, infecting and killing unknown numbers of peoples in northern and western Africa. Though the influenza pandemic of 1918–19 lasted two years, cycling through three major waves, its viral etiology was discovered in 1933 and an effective vaccine developed in the 1950s. The 2009 H1N1 influenza generated some 60 million worldwide cases, fewer than an estimated half a million deaths, and a vaccine by December 2009.

Before a vaccine, secondary bacterial infections have to be controlled. It is ironic that hospitals were/are the locus of treatment as well as the source of bacterial infections. A slippery slope among capitalism, medical innovation, and health care existed then and now: pharmaceuticals invests millions in drug research and development and, in short, antibiotics are not worth it because companies who develop new ones must wait or risk deploying them, allowing bacteria to generate even stronger resistance and making the antibiotic obsolete. The net result has been fewer and fewer antibiotics as more companies file for bankruptcy. And yet, in the age of COVID-19, antibiotics are needed more than ever to combat secondary infections for hospitalized COVID-19 patients. Unlike the influenza viruses of 1918–19 and 2009, COVID-19 is a different creature, divergent from the seven coronaviruses identified by scientists since the 1960s. COVID-19, like the pandemic of 1918–19, shook the foundations of biosecurity—the idea that biomedical measures can protect us against threating microorganisms—but will its edifice, its existing structural and epistemological principles, remain intact after COVID-19?

If northern regions in the Gold Coast suffered disproportionally from the pandemic of 1918–19, then thus far COVID-19 has had the very opposite outcome. At the moment, Ghana is neither South Africa, ranked thirteenth in the world with over 732,414 confirmed cases, nor is it Eritrea, with 484 confirmed cases and zero deaths. Statistics are imprecise and always open to question, especially in times of relative testing and contact tracing. But here they give us a sense of broad patterns and allow for analysis, qualified by the dangers of comparison. Of Ghana's 48,788 confirmed cases and 320 deaths, more than half of those cases are in the Greater Accra region, home to the densely populated capital of Accra. Further north, into the forested interior, in the Asante region, we find the next largest batch of cases—currently notched at 11,029—in and around the regional and equally dense capital of Kumase. Still further north, the numbers dwindle significantly into the hundreds and then into single digests. These are the sparsely populated areas ravaged by the pandemic of 1918–19.[14] Today, they are virtually untouched. But why? Ghana possesses 33.6 million acres of arable land, yet only 12 percent is used. Ecological

endowment and abandonment plays out in the socioeconomic divisions of the country, reified during the colonial era. The line from poverty to prosperity flows from the more Islamized northern regions to the Christianizing southern parts, where we find further paradoxes: manufacturing industries are concentrated in the coastal zone with attendant pollution, waste management, and migration issues, whereas villages that tend to be cleaner than cities enjoy a lower quality of life due to the asymmetrical distribution of resources and investments.

Though the contrasts between the north and the south predate colonial rule, British imperialists sided with Akan views of the north, as uncivilized and backwards, and institutionalized them. But because of its built-in social distancing, lack of dense urbanized spaces, and its "underdevelopment," northern Ghana pokes at the blind, almost devotional rush to imitate European and North American approaches to cities, to institutional building and infrastructures suitable to local ecologies and their cultural occupants, and to housing, poverty, and health care. The influenza pandemic of 1918–19 moved slowly in Africa, due to otherwise poor transportation networks, which, counterintuitively, was a net positive—the Gold Coast and much of Africa quickly recovered from a pandemic that killed between 20 and 50 million worldwide. I am not suggesting a return to or an approval of poor roads. But I am asking we suspend our belief in European-designed roads and rails built for extractive industries and ecologically destructive practices that facilitated the spread of pandemics and opened up pristine forests to unchecked malaria and other maladies. Let's return to South Africa, the second largest economy in Africa and the most industrialized, often drawing comparisons to Eurasian states. Gauteng is the most populous and highly urbanized province, with the country's largest and wealthiest city, Johannesburg. This province has the highest number of confirmed COVID-19 cases, currently at 229,702, followed by KwaZulu-Natal and Western Cape, whereas the Northern Cape has the second lowest number of cases (27,210) and yet largest and most sparsely populated province, like northern Ghana.[15] Even Senegal's densely crowded capital city of Dakar accounts for most of the country's confirmed cases. The semi-urban and rural areas outside of Dakar, like Ghana's Accra and Kumase, stand in sharp contrast.

If epidemics hold up a mirror to prevailing sociopolitical conditions and more, then surely COVID-19 has the possibility of guiding stakeholders to fortify less existing structures and rather build institutions and communities that are not at odds with local ecology and humanistic values.[16] There is also the possibility of forgoing imitation. COVID-19 has laid bare the imperatives to do so and with urgency, because African lives are at stake. It would take permanent blindness not to notice how the warped health care systems in so-called developed countries, touted as "advanced" in gadgetry and medication regimes, have been exposed as violently racialized and acutely inaccessible, in particular for the poor and

marginalized. Also on full display are the ways in which rampant individualism and quasi-sacred notions of individual freedoms work as accelerants in places like the United States, the current world leader in COVID-19 cases, notched at 9.6 million, and over 234,911 deaths. Add to these Brazil and its 5,590,025 cases, India with 8,364,086 cases, and Russia with 1,699,695 cases. We can see stridently autocratic governments in all, serving as compelling evidence for Africa to look away from these and rather within—that is, Africa and global Africa—for leadership that serves it peoples rather than elite interests.[17]

COVID-19 is also making clear what is at stake, on multiple fronts. There are currently fewer than two million confirmed cases and under 45,000 deaths in Africa. Almost half of these cases are located in southern Africa. Western Africa stands at 192,762 confirmed cases and fewer than 3,000 deaths. In this region, Nigeria, which has the largest economy and population in Africa, and then Ghana stands out. After Ivory Coast, Senegal, Guinea, and Cape Verde, the nine remaining nations belonging to the region have 4,000 or fewer confirmed cases. Once more, the precision of these numbers, or whether enough testing and tracing is occurring, is important but not essential, compared to the patterns at which they hint. Epidemics show where power is and power is not. Far from egalitarian, these microorganisms share much with humans: they want to survive and they possess their own biases toward the displaced, the poor, and the marginalized living with poor health and economic conditions. Who does the work in an epidemic and what is the value of work and the worker, deemed essential and thus exposed? Which parts of an economy remains open while other parts close? These questions represent the real-world conditions for people like midwife Philomena Owusu Domfe, who is an essential worker at the Ridge Hospital in Accra, Ghana's epicenter for COVID-19. For Domfe and millions like her, proximity with patients (or customers) is a job requirement. She has to protect herself, the expecting mother and child, and her own family when returning home. Who protects and supports the essential worker when they are infected and have to quarantine or, worst, be hospitalized? For many, protective gear and water and soap to constantly wash hands are not givens. They are luxuries.[18]

Historians, other scholars, and the general public are all eyewitnesses.[19] I began this article by saying no one writes history as it is happening, which is to say there is a difference between chronicling and history writing. Some have suggested we record, through diaries and other devises, our observations in the age of COVID-19. Many have begun to record their lived experiences, of themselves and of the times, assuming their experiences will have future historical significance, neglecting to contemplate how COVID-19 will be relegated to history—that foreign land called the past—rather than a spectacle appearing now and again. The further away we move from the COVID-19 moment the more we might

lose the human stories crafted in that moment. And yet those stories, like that of Philomena Owusu Domfe, might become just data points a decade or century later. Rationalization and number crunching does reduce the human. And although we might guard against that reductionism, future historians may need to explore gigantic datasets, however crude and inhumane, using social science methodologies to tease out large patterns. Bringing into dialogue big data and private journals and social media artifacts, tempered by confinement and inhibited social distancing, will open up how people lived through the global and the local, through politics, cultures, and memory.

How will COVID-19 be remembered is still up in the air. There is a possibility it will be linked to climate change and environmental action, because climate change and COVID-19 are coterminous in their global reach and perhaps effect, though both affect us unequally. There is also the possibility we remember when WHO declared COVID-19 a pandemic on March 11 and the innovative African responses to the disease. Emerging from one of earliest world regions to respond to COVID-19, African innovations included contact tracing apps, data analytics systems, diagnostic testing kits, mobile testing booths, and inexpensive hospital beds.[20] On March 4, Nigeria became the first African nation to sequence the SARS-CoV-2 genome, the virus that causes COVID-19. Senegalese researchers created an immune-based, COVID-19 diagnostic test for $1.00, while Ghana also produced an inexpensive antibody test and used Zipline drones to convey virus samples to testing sites. Kenya began producing millions of masks, Rwanda went cashless, relying on a digital economy and mobile transactions, while also using drones to make public broadcasts and robots to monitor patients.[21] These innovative responses, taken together, demonstrate what Africa and Africans can do, especially when measured against the linked reality of resource scarcity and kleptocratic governance.

For all the caution about comparisons and analogies, in hopes of wrapping our minds around living through a pandemic, there may be a more urgent and sobering need for Africa and the world, standing at a particular precipice and facing known challenges anew. Addressing COVID-19 can by extension offer a reckoning with structural and ideological challenges. African countries, especially south of the Sahara, live under the cryptic fiction of independence and that fiction props up kleptocratic governments and their institutional means of grand larceny. Ghana's median age is 21.5, with 57 percent of the population under 25. Many of these young people have begun to disassemble this fiction. In a generation, that is, 30 years, Africa's under-25 population will constitute half the continent's people. This youthful Africa stands oddly in contrast with Africa being the home of many of the world's oldest and longest serving heads of state. We may need to live with COVID-19 as we have done with HIV/AIDS, but there is no comparative

outlook for living under placeholders for collective and responsive governance. Even among members of various parties and election participants, there is little verifiable trust in African governments. The immediate political consequences of COVID-19 will be most visible in the recent and coming presidential elections: Ivory Coast and Guinea in October 2020, Burkina Faso in November 2020, and Ghana in December 2020. These will be litmus tests for the challenges ahead. For one, there is reasonable opposition to whatever vaccines become available and if or how Africa will be a laboratory for them. The relationship between publics and science is contested; in global Africa, COVID-19 triggers historical flashbacks and the conjurings offered by colonial science. Then, how long can people no longer working and who found it nearly impossible to find gainful employment before COVID-19 survive? Finally, there is an assumption that everyone has a home: an estimated 150 million are homeless and over 1.5 billion have inadequate housing. COVID-19 has exposed but will continue to explode these numbers.

NOTES

1. See Edward Paice, *World War I: The African Front: An Imperial War on the African Continent* (London: Pegasus, 2008); Hew Strachan, *The First World War in Africa* (New York: Oxford University Press, 2004); Melvin E. Page, ed., *Africa and the First World War* (London: Macmillan, 1987); Richard Rathbone, "World War I and Africa: Introduction," *Journal of African History* 19, no. 1 (1978): 1–9.
2. K. David Patterson, "The Influenza Epidemic of 1918–19 in the Gold Coast," *Journal of African History* 24, no. 4 (1983): 485, 501.
3. See, for instance, Georges Nzongola-Ntalaja, *The Congo: From Leopold to Kabila: A People's History* (New York: Zed Books, 2002); Adam Hochschild, *King Leopold's Ghost: A Story of Greed, Terror, and Heroism in Colonial Africa* (Boston: Mariner Books, 1998).
4. See Craig Timberg and Daniel Halperin, *Tinderbox: How the West Sparked the AIDS Epidemic and How the World Can Finally Overcome* (New York: Penguin, 2012).
5. See R. Bagulo Bening, "Internal Colonial Boundary Problems of the Gold Coast, 1907–1951," *International Journal of African Historical Studies* 17, no. 1 (1984): 81–99.
6. *Colonial Report—Annual. No. 306. Gold Coast. Report for 1899* (London: Her Majesty's Stationary Office, 1900), 22. But see also the vital statistics section of colonial reports 189 to 894, c. 1896–1916. On "colonial medicine," see Reginald Cheverton papers, MSS Afr. s. 2276, Bodleian Library of Commonwealth and African Studies at Rhodes House (Weston Library), Oxford University.
7. On Takyiman, in the history of Gold Coast/Ghana and as it relates to health and healing, see Kwasi Konadu, *Our Own Way in This Part of the World: Biography*

of an African Community, Culture, and Nation (Durham, NC: Duke University Press, 2019).

8. Quoted in Patterson, "The Influenza Epidemic," 491.
9. *Colonial Report—Annual. No. 271. Gold Coast. Report for 1898* (London: Her Majesty's Stationary Office, 1899), 31.
10. *Colonial Report—Annual. No. 573. Gold Coast. Report for 1907* (London: Her Majesty's Stationary Office, 1908), 45; David Scott, *Epidemic Disease in Ghana, 1901–1960* (New York: Oxford University Press, 1965), 2, 4, 74, 81, 128, 187–92; Patterson, "The Influenza Epidemic."
11. Public Records and Archives Administration Department, Sunyani, BRG 9/1/1, Letter from Commissioner of Western Province of Ashanti to the Omanhin of Tekiman, Sunyani, 9 May 1917.
12. Dennis M. Warren and K. Owusu Brempong, *Ghanaian Oral Histories*. Papers in Anthropology, no. 8 (Ames: Anthropology Program at Iowa State University, 1988), 2 (but see also 4, 74, 81, 128).
13. Dennis M. Warren and K. Owusu Brempong, *Techiman Traditional State, pt. II, Histories of the Deities* (Legon, Ghana: Institute of African Studies, University of Ghana, 1971), 59–60.
14. COVID-19: Ghana's Outbreak Response Management Updates, accessed November 5, 2020, https://www.ghanahealthservice.org/covid19/.
15. Nickolaus Bauer, "'No longer at a crossroads': S. Africa's enduring COVID-19 battle," *Al Jazeera*, July 27, 2020, accessed July 31, 2020, https://www.aljazeera.com/news/2020/07/longer-crossroads-africa-enduring-covid-19-battle-200727060314872.html.
16. See Frank M. Snowden, *Epidemics and Society: From the Black Death to the Present* (New Haven, CT: Yale University Press, 2019).
17. The Johns Hopkins Coronavirus Resource Center, accessed November 5, 2020, https://coronavirus.jhu.edu.
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19. Mary Lindemann, "The Historian and the Virus: A Time Capsule from Mid-March," *Perspectives on History* 58, no. 5 (May 2020): 9–10.
20. "WHO showcases leading African innovations in COVID-19 response," May 21, 2020, accessed July 31, 2020, https://www.afro.who.int/news/who-showcases-leading-african-innovations-covid-19-response.
21. Youssef Travaly and Aretha Mare, "Learning from the best: Evaluating Africa's COVID-19 responses," *Brookings Institution*, July 8, 2020, https://www.brookings.edu/blog/africa-in-focus/2020/07/08/learning-from-the-best-evaluating-africas-covid-19-responses; Afua Hirsch, "Why are Africa's coronavirus successes being overlooked?" *The Guardian*, May 21, 2020, https://www.theguardian.com/commentisfree/2020/may/21/africa-coronavirus-successes-innovation-europe-us; United Nations Economic Commission for Africa, "Stories—Innovations in

Africa on COVID-19," accessed July 31, 2020, https://www.uneca.org/aiif2020/pages/stories-innovations-africa-covid-19.

KWASI KONADU is John D. and Catherine T. MacArthur Endowed Chair and professor at Colgate University, where he teaches courses in African history and on worldwide African histories and cultures. He is the author of *Our Own Way in This Part of the World: Biography of an African Community, Culture, and Nation* (Duke University Press, 2019), (with Clifford Campbell) *The Ghana Reader: History, Culture, Politics* (Duke University Press, 2016), *Transatlantic Africa, 1440-1888* (Oxford University Press, 2014), *The Akan Diaspora in the Americas* (Oxford University Press, 2010), among other books.