AFRICA KNOWS!

ASC/AEGIS, 2-12-2020 / February 2021 (ON LINE)

E.29:

Covid-19, local knowledge and university training. A new opportunity

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DRAT (not to be cited)

In April I wrote an article on the prospects for the Covid19 in Africa, particularly south of the Sahara** It was intended to contribute to the feeling of not a few close observers and experts who observed with concern how the international community was establishing a planetary regulation that did not appear to be in keeping with either the epidemiological expectations of the African subcontinent or the potential of its health and administrative structure nor the functioning of its social fabric. The handful of voices I joined were drowned out - though not silenced - by the media, both local and international. Debtors of their own informative snowball dynamics - so many times useful -, they constructed almost without exception an apocalyptic message, in accordance with the usual imaginary about Africa.

Five months later, the minority prediction has been fairly fulfilled in terms of the moderation of the pandemic in sub-Saharan territory**[1]. . In South Africa alone (the country most affected on the continent) more people die each year of cardiovascular diseases (at least 40-45,000, my own projection from WHO's data[2]) than those produced by Covid 19[3] throughout the continent (some 36,000, around 25,000 south of the Sahara, for a population of over 1,036,000,000, equivalent to an absolute mortality of 0,025/1000 and a "specific" one, or relative to the cases detected, of 22/1000). The comparison with malaria[4] provides clues to the (ir)rationality of the health effort generated by the pandemic in Africa: according to WHO data, last year malaria affected over 213 million people in the subcontinent, with almost 400,000 deaths (an absolute morality of 0.37/1000 and a specific, or relative to the cases of the disease itself, of 1.7/1000), for 1,164,000 cases of Covid19 (5 October) with the mortalities already mentioned.

I do not intend to deny the need to take COVID19 very seriously in the southern Sahara: Its specific mortality rate is high with respect to malaria, which is worrying in environments with major health deficits; however, this incidence, which is to be expected in a situation of epidemiological novelty, is lower than in other highly affected non-African countries (in Spain

[1] This interpretation comes from different entourages, no only from Africanists, scientific or activist, but even from such neoliberal instances as Davos Forum https://www.weforum.org/agenda/2020/10/3-factors-african-continent-beat-covid-19-predictions-who-drones/

[2] https://www.world-heart-federation.org/wp-content/uploads/2017/05/Cardiovascular_diseases_in_South_Africa__Spanish_.pdf

[3] All Covid19 statistics come from Worldometer and Who, and have been consulted for the last time on 5th October 2020.

[4] https://www.who.int/malaria/media/world-malaria-report-2019/es/ It hast to be taken into account that WHO's African Health Region overlaps with Sub Saharan Africa, just adding Algeria.

the rate is 40/1000 for the same date), and even more so if the South African figures are separated; furthermore, the level of concern about Covid19 in the region would also have to be modulated in view of its clearly lower volume of infected people and health burden compared to other diseases.

In any case, it is clear that these are evolving numbers, and that they could be influenced by a foreseeable under detection of cases and by the weighting of the hypothetical global increase in mortality, statistical corrections that depend on future research. Precisely, at a recent workshop on local reactions to the Covid19[5], held during a conference that was the first impulse for a new tricontinental (triangulating between sub-Saharan Africa, Latin America and southern Europe, at first), it became clear that the pandemic, mild or not, is still in force and the research it requires is still very incipient on both sides of the Atlantic. However, some lessons could already be detected, on the basis of which I would like to build this communication. For the time being, I would point out two particularly related to this panel.

Firstly, in sub-Saharan Africa as a whole, the negative effects of Covid19 have been mainly due to the measures taken to prevent the spread of the disease, much more than to the infections themselves or the costs of their treatment.

Secondly, the inadequacy of the forecasting and planning of the response to Covid19 in Africa which emerges from the previous observation is deeply related to the exclusion of what we could call local knowledge from the analysis, health systems, training of professionals and the design of health policies.

With regard to the first lesson, it should be said that the Covid19 has generated an infinite number of conditioned and comparable observation situations which facilitate a massive contrast of observations, making it one of the most usable equivalents of global experimentation in recent decades, in the social sciences, and also in the health sciences (which do not cease to intersect as much or more with sociology or anthropology than with biology...). By stressing health systems, the pandemic has exposed the shortcomings of the universally accepted global health system through the ODS: the response has hinged on borders that lack solidarity, as in the old model of international health (the competition for a vaccine is particularly revealing, and scandalous in this respect); consequently, and as in very recent times but more embarrassingly given the unexpected "northern" distribution of the disease, the general regulations have responded to the needs of the most developed countries rather than planetary planning that takes into account the differences (in needs and potentials) of each region; the evanescence during the crisis of private health care associated with scientific medicine, has made clear the perversion of an international system without its own budget and which has been undermining the public health of each and every state for decades... *** And so it could be continued and deepened. But this is not the aim of this communication: I propose, therefore, on this scenario, to return to the second great learning process.

At a local level, the evaluation and epistemological reading that can be made of this quasi-historical experience is quite different from the global analysis. If the global health system and the dynamics and actors that drive it have been disempowered, the very diverse local health systems, their actors and practices have been strengthened as a whole, at least in sub-Saharan Africa. On the one hand, the African National Health Systems, which are dependent on and so

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[5] https://www.who.int/malaria/media/world-malaria-report-2019/es/ Hay que tenir en cuenta que la región sanitaria africana de la OMS coincide pràcticamente con el Áfica subsahariana (añadiendo Argelia).

often not supported by cooperation, have been able to put on the medal of effectiveness, arguing that their rapid adoption of the mechanisms recommended by the WHO has allowed the "control" of the pandemic in Africa; this good management has legitimised their demand for greater resources from the international community if they want to advance the 2030 objective of global health[6], as well as the request for greater participation and local specificity in the setting of the rules of the game and in the articulation of general health policies[7] ***.

In addition, the even partial adoption of strategies of confinement and social distance (more accessible in economic terms than detection on the ground and separation of sick people) has led to socio-economic difficulties that virtually no state*** has been able to counter effectively; these difficulties have also had a health dimension that populations have faced in the main through solidarity mechanisms other than those provided by the state, often using non-scientific, traditional and other therapeutic systems. This observation seems to argue in favour of returning to, implementing and deepening* the WHO's recommendations on TCM and community health, which were practically forgotten during the pandemic. This means taking up the challenge of incorporating local knowledge into public health systems and, consequently, into formal, primary, secondary and higher education. And it is not hidden from anyone that such an evolution would open the door of universities and agencies to local knowledge from other fields (agriculture, forestry, population administration...).

However, this paradoxical situation, in which the disinherited of the modern health approach* seem to unexpectedly claim a place in the sun, has raised, and/or will raise suspicions, the kind of suspicions that have always accompanied local knowledge in contemporary contexts. Is this not a kind of "secondary elaboration" in the sense used by Evans-Pritchard, in his famous *Witchcraft, Magic and Oracles among the Azande*? Secondary elaborations are discourses and practices associated with forms of knowledge in such a way that, based on ambiguity or subjectivism, they always allow for the justification of the system of thought and power on which they are based, even when the results are bad: in this case, personal responsibility is denounced (a bad performance by the expert), never systemic one (an erroneous worldview). A typical example is the association of divination mechanisms (ordeals, random disposition of interpretable elements....) to diagnostic systems (therapies) or arbitration systems (judgements).

In this case, it could be argued that both African ministries of health and traditional therapists are sticking their chests out on the basis of a situation they have barely influenced, with other causes (ecological and social***) actually explaining the control of the sub-Saharan pandemic.

Without completely rejecting this bias created by a supposed spontaneous remission in SARS-cov2 activity in Africa (i.e. a kind of regression to the mean, given our ignorance about the normal cycle, degree of prevalence and virulence expected in the disease), it is clear that such an interpretation neither denies the indicated effects, nor allows us to ignore its consequences. On the one hand, there is no doubt that the NHS has handled the international discourse well and their claims are totally coherent and necessary for the objective of global

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[6] See the example of Senegal (16M; 15.122 cases; 312, deceased), that has been claiming its role in the pandemics since at least May, as well as projecting the Covid19 related research over a largest framework (see the studies of Abdou Salam Fall team, in the UCAD, Dakar; see also https://www.africaradio.com/news/le-senegal-se-veut-moins-dependant-de-l-etranger-dans-l-apres-covid-19-173301#_blank)

[7] An example: the Alliance between India and South Africa about a new global policy on IPR in the health field: https://apnews.com/article/virus-outbreak-technology-global-trade-international-agreements-india-c65a718f35f40cb50402f67018efb8e5 .

health. On the other hand, the socio-economic stagnation caused by Covid19 is not a bluff, and local resources have been the only answer to it. Evans-Pritchard's interpretation and that of British social anthropology in general on African therapies and their thin line of separation from witchcraft, explored their functions with respect to social cohesion, but neglected the measure of their effectiveness on the level of health or prosperity of populations.

In the current state of communication (itself a milestone in my personal research person, that I am trying to insert in collective work), I will point out some lines of interpretation of data in the field, some research tracks, which point to the necessary incorporation of local knowledge in the obliged local connection when strengthening a public and really global health system, another of the great lessons we have accumulated in the "Covid experiment", although more than insists on ignoring it. The clues are concentrated in 3 countries with relatively similar eco-sanitary conditions, which can optimise the comparison (between each other and then with other cases): between 50% and 100% of their population dwell in highlands, areas that are susceptible to low temperatures even in intertropical latitudes, temperatures which can lead to higher activity of different flu strains and perhaps also SARS-cov2, as is the case in South Africa; all of them are countries with a low level of development and strong deficits in the NHS; all of them have undergone major political changes since the 1990s, although within a context of relative stability and, in all of them, factions of the elites postulate the existence of local political ethics that have converged with Christianity in a process of modernisation.

Scenario 1. Madagascar
(25 million; HDI, 0.521 [157]; 16,570 cases and 233 deaths, at the end of the southern winter)

Already in April, the Malagasy President, Patrick Rajoelina, announced the production of a remedy for the coronavirus, which he immediately tested personally**. The announcement made headlines around the world. In general, the presidential initiative was dismissed as populist pseudo-science**. However, the artemisinin trial was well comparable to those being conducted by French anti-malaria laboratories, for example; and the results, that were subsequently contrasted by centres of reference such as the Max Plank Institute, can be understood as partial and promising at the same time as those that gave the near exclusive green light in the European Union to *Redemsivir*, manufactured by the Guilead corporation. This media discrimination, however, has had a limited effect regionally and locally. IMRA (Institute Malgaches de Recherche Appliqué), the institution that has promoted the remedy locally, with a history well previous and independent from the President, has been reaffirmed, both internally and externally (new partners). The president's proposal to make the remedy available to the population, while promoting parallel research about its effects, has been taken into account by at least 37 African countries. And the proverbial recourse to traditional medicine on the Red Island enjoys more prestige than ever, as a university professor, and director of a museum in the capital, corroborated personally.

Scenario 2. Rwanda.
(12.7 million; HDI, 0.536 [162]; 4,867 cases and 29 deaths),

Rwanda established strict containment measures from 22 March, undoubtedly among the most rigorous and effective (in the sense of compliance) in Africa and perhaps in the world. And it has continued with strong measures of social distancing, with a level of investment in the alternative model to confinement - that of detection, tracing and separation, assisted even by drones - unparalleled on the African continent**. In any event, the degree of control of the disease has been very high, both in terms of transmission and of specific mortality (eight times lower than in Spain). This low incidence may well have been influenced by the strong geographical isolation of Rwandan society. But this does not mean that there are no lessons to

be learned in Rwanda: on the - exceptional - economic and welfare involvement of the state in a low-income country; on the discipline of the populations in the internalisation of health standards which are in principle imposed in the name of the common good, but which are imposed in the end; on the articulation of popular and official forms of solidarity ...[8] Being Rwanda an authoritarian regime, analyses interpreting this effectiveness as an attempt to legitimise internationally the optimisation of the mechanisms of repression of any opposition are certainly correct. But once again, the detection of this instrumentalization (which offers an African scenario for the discussion about the dubious goodness of authoritarianism in the face of health insecurity) is not contradicted by the opportunity to study the aspects mentioned, aspects that are understandable as articulated forms of local knowledge.

Scenario 3. Ethiopia
(99 million; HDI, 0.479 [173]; 79,437 cases and 1,230 deaths)

Ethiopia often appears as one of the Covid19 "hot spots" in Africa, along with neighbouring North Africa and South Africa. However, both the incidence of cases in relation to the population and mortality, general or specific, remain at clearly low levels. In fact, the government itself has recognised the lack of realism and basis for the initial forecasts, which followed those of a WHO led by an Ethiopian (and its recommendations were also followed). As in Madagascar and Rwanda, the isolation factor may have played a certain role, despite the growing weight of Ethiopian Airlines on continental flights. As in the other two countries, the main effect of the Covid19 on the populations seems to be economic, paralysing the industrialist promise that a good number of analysts anticipated in the country. In Ethiopia, this gloomy outlook has been accompanied by the almost usual food pre-alerts; however, so far (and as so often in the 21st century), famines do not appear to have materialised. In any event, everything points to a more solid "domestic economy" than is usually recognised, especially in this time of political transition, which is marked time and again by strong social upheavals. The strong and complex solidarities of the diverse Ethiopian social fabric could explain this elasticity: traditional systems of land tenure such as *gult* or *rist* in the core of ancient Abyssinia, or the *gada* age group system in Oromo regions, converge with structures bequeathed by the socialist regime such as the Peasant Associations, and with a long and intense interaction with the international system of cooperation, starting with USAID... The result is very dynamic and understandable mainly in terms of local knowledge. It is even possible that the Covid19 has had a paradoxical effect, by making the economy more precarious, but legitimising the adoption of exceptional measures that could allow a more pathed and effective political transition

These scenarios are certainly susceptible to comparisons between themselves and also with other regions, partial or global comparisons. For example, the large cities of the Malagasy or Ethiopian highlands can be studied on an ecological framework comparable to those of the hinterland of the RSA (Johannesburg, Pretoria**) or Kenya. However, as attractive capitals, they can be compared with Dakar or Cape Town, despite these last being locates in shore lowlands Crossing comparing combinations can be very conducive to obtaining contrasting results which can be applied specifically (once they have been nuanced or adapted), and not just pretend to constitute a universal pattern.

In any case, the communication aims to show a moment of research, but taking into account some partial results (however much they may need to be re-contrasted). I will point out some of them to indicate the work to be done and to close this approach for the moment.

[8] The author has started a systematic research of this elements in collaboration with the Institute Catholique de Kabgayi.

. The African experiences in relation to Covid 19 points to the convenience of activating the WHO strategies for integrating TCMs and community health in NHS. This activation implies political and budgetary decisions that need to be studied.
. The WHO's normative capacity in this field (and in general) can only be strengthened if the participation and autonomy of the TCM and community health systems involved are ensured.
. The necessary training in health sciences must take into account this therapeutic pluralism, but if it is to remain effective (often partial, but multidimensional, depending on the holistic and participatory approaches of local social and health systems), it should do so without trying to subsume it, without trying to translate, purify or replace the other actors, but by learning to act on their behalf, in a regime of co-responsibility.

These learnings imply strong challenges - epistemological, pedagogical and professional - that are intended to be developed in the full communication and discussed in the panel.