# COVID-19 And the Lessons from Earlier Pandemics in Africa

**Q&A with Kim Yi Dionne**, Assistant Professor of Political Science, University of California, Riverside

*What lessons from earlier pandemics – like AIDS and Ebola – should we be drawing for the COVID-19 pandemic?*

There are two lessons that I think are really important. First, pandemics are particularly challenging for government response because they require the coordination of multiple actors across levels of governance (Benton and Dionne 2015; Dionne 2018). These actors represent the interests of multiple – often not overlapping – constituencies. Ultimately, the success of multi-tiered interventions like the global response to COVID-19 will rely on the decisions of ordinary people to change how they regularly go about their lives in order to stop the disease's spread.

On citizen behavior, the second lesson that we can learn from earlier pandemics is about citizen trust. Both the AIDS and Ebola pandemics in Africa have shown that citizens who do not trust their governments may be less likely to accept public health campaign messages and adopt the behavior change necessary to stop the spread of infection (Blair, Morse, and Tsai 2017; Arriola and Grossman *forthcoming*). To be effective at promoting behavior change, health interventions can employ agents that citizens trust, such as religious leaders and local leaders, the latter including headmen, chiefs, or other traditional authorities (Seay 2013; Dionne 2018; Arriola and Grossman *forthcoming*).

*Did previous pandemics influence African states' responses to the COVID-19 pandemic? In which ways?*

While the average person might think of African states as under-resourced, African experiences navigating recent pandemics also meant there was some capacity to respond to COVID-19 that other, better-resourced states might not have.

Take the example of HIV/AIDS intervention in South Africa as preparation for COVID-19. It was on March 5, 2020 that the first COVID-19 case emerged in South Africa. The government implemented a 21-day national lockdown that commenced on March 27, 2020 – the same day South Africa recorded its first COVID-19 death. South Africa has employed mobile HIV testing (often coupled with tuberculosis screening) for over a decade. At the start of the national lockdown, South Africa's health ministry deployed community health workers and at least six mobile screening and testing vehicles in four of South Africa's nine provinces, with plans to deploy 20 more mobile units across all provinces in April. Comparing the South African case

to better-resourced states in the global north shows a much more rapid response and one that seemed to have greater capacity to coordinate community-level testing.

### *How have African states been working to insulate themselves from a pandemic that had at first predominantly affected other locations?*

Many African states closed borders. For example, Uganda shut its borders to all but cargo (and only under certain conditions) after its first COVID-19 case emerged when a Ugandan national returned from Dubai with a fever.

Because COVID-19 cases first emerged in China, the initial response involved curtailing travel from China. However, as the pandemic spread, a greater threat to African states were travelers coming from Europe and North America. Benton (2020) points out how early in the outbreak many "African" cases of COVID-19 were visitors from the U.S. and Europe, who have great freedom of mobility across borders. As cases emerged on the continent, African states began curtailing travel from heavily-affected countries like the U.S., Italy, and the U.K.

Before closing borders and curtailing incoming flights, the relatively recent experience of travel-introduced Ebola infections prepared many major African airports – working with their respective ministries of health – to screen passengers arriving by air. Unlike in the U.S. for example, where government travel restrictions early in the COVID-19 pandemic led to overcrowding in airports absent rigorous medical screening, multiple African airports had health workers questioning and taking temperatures of inbound travelers.

### *Do you see any regional or regime type based patterns of response to the pandemic in Africa?*

There are multiple disturbing reports of soldiers and police officers using deadly force to enforce national curfews and lockdown orders. In Kenya's capital city Nairobi in late March, residents of the Mathare neighborhood reported police officers fired tear gas, shot guns in the air, and beat people with canes to enforce a dusk-to-dawn curfew. By mid-April, a human rights commission had issued a report that more Nigerians had died from aggressive enforcement of COVID-19 lockdowns than from the coronavirus itself (National Human Rights Commission 2020).

African states that have engaged more regularly in violent repression may use the threat of COVID-19 to justify using deadly force, potentially targeting opposition or activist organizations. Just like states can draw on their previous experiences and relevant capacity to handle epidemics, states can also draw on their previous experiences and capacity to repress citizens in the name of health security.

The earlier scholarship on regime type and health (see e.g., Lake and Baum 2001) should lead us to expect citizens in democracies may get more or better health services during the COVID-19 pandemic than their counterparts in autocracies. To be sure, it is too early to speculate which regime type will be more effective at both curtailing COVID-19's spread and caring for those who become infected and ill. Comparing early responses to COVID-19 beyond Africa, however, suggests openness and transparency has worked better than coercion (Kavanagh 2020). Future research could examine in the current pandemic to what extent democracy and more specifically, levels and forms of democratization matter for public health in African states (Grépin and Dionne 2013). ●

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