

## A test of dignity: an anthropological analysis of Covid-19 responses in West Africa

**Yannick Jaffré** • Anthropologue, directeur de recherche émérite au CNRS

**Hélène Kane** • Docteure en anthropologie de la santé, chercheuse associée à l'Unité mixte internationale Environnement, Santé, Sociétés (CNRS UMI ESS)

**Fatoumata Hane** • Socio-anthropologue, maître de conférences à l'Université Assane Seck de Ziguinchor (Sénégal)

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The three authors of this article conducted an anthropological analysis of the Covid-19 pandemic as seen from and experienced in Africa, shedding valuable insight into how this pandemic has been perceived by the continent's populations, scientists and politicians. It also – and perhaps most importantly – offers an astute interpretation of the representations made and the demands for dignity expressed.

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**E**vidently, this was a health pandemic. But its appearance was too sudden, massive and alarming to prevent the uncertainty surrounding the risks caused by the dissemination of the virus from affecting the habitual rationality of our health choices and engaging – in a variety of ways – our political emotions and the credence we give to medical expertise.

Everywhere, these not directly medical dimensions – the choice of public health strategy, use made of available knowledge and impact of the fanciful powers of epidemic narratives – have shaped the sociotechnical spaces of Covid-19.

It is this configuration of the epidemic, opposing the infectious characteristics of the virus to its modes of transmission, with the socio-historical dynamics driving the specific health responses of the countries affected by it, that we endeavour to describe here.

We are writing without the benefits of hindsight. The epidemic is ongoing and its progression is uncertain. Moreover, we still lack data and would need to conduct numerous field studies – which is currently impossible – to support our assertions. The goal of this exploratory work on “*signes, traces et indices* [signs, traces and clues]”<sup>1</sup> is therefore to help define a set of dimensions that are all too often overlooked in exclusively health-based studies, despite helping to shape epidemic responses. In the field of health, as much as anywhere else, the implicit cultural issues and political emotions<sup>2</sup> influencing the interpretation of an event determine the decisions and actions taken by its stakeholders.

### Health policies and social contradictions

In West Africa, the focus of our analysis, it is easy from a public health point of view to demonstrate the rapidity of the health response to Covid-19 and the efforts made to implement coherent measures across all the countries in the sub-region.

For example, as the first cases of the virus were “imported”, within the space of ten days – between 16

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<sup>1</sup> Carlos Ginzburg, « Signes, traces, pistes : Racines d'un paradigme de l'indice », *Le Débat*, 6 (6), 1980, p. 3-44.

<sup>2</sup> Arjun Appadurai, *Géographie de la colère*, Payot & Rivages, 2007 ; Dominique Moïsi, *La Géopolitique de l'émotion*, Flammarion, coll. « Champs actuel », 2010.

## HUMANITARIAN ALTERNATIVES

and 26 March – all the member countries of the Economic Community of East African States (ECOWAS) closed their borders, with the exception of Liberia. They then went on to close schools, universities and public gathering places, introduce a “curfew” and – unlike certain Heads of State in the North – strongly encourage and in some places impose the wearing of masks and the application of basic hygiene measures. “In France, after the first case, it took 52 days to implement some measures, by which point there were some 4,500 cases. In Côte d’Ivoire, the schools and the borders were closed just 5 days after the first case. One week later, a curfew was in place”, recounts Dr Jean-Marie Milleliri<sup>3</sup>.

Moreover, these prevention measures were often demonstrated publicly by the heads of State in person, as in Senegal and Côte d’Ivoire, and by other political leaders and even by performance artists such as the Senegalese singer, Ismaël Lö, the Congolese singer, Koffi Olomidé, or the rap group, “Y en a marre”. Similarly, a number of political personalities, including the Prime Minister of Côte d’Ivoire, Amadou Gon, set the right example by announcing that they were self-isolating after being in contact with a person who had tested positive to Covid-19.

Of course, it wasn’t the same everywhere. While some political leaders spoke out, others remained silent. And the timeline for the implementation of actions and measures was variable. In a situation of considerable anxiety and uncertainty, however, we saw management that was, on the whole, quite “routine”, even in its contradictions, with Niger and Senegal still obliged to negotiate with their country’s religious authorities and Mali and France organising legislative elections while locking down.

While this image is not false, it nevertheless contains some cracks and nuances that must be examined. To understand the “natural course of the epidemic” we must first map it and identify the fault lines and ideological modifications that this health event has generated. Fault-lines and tremors which, from one country to another, and between the continent and the diverse diaspora, in a now largely “digitalised” Africa<sup>4</sup>, were prolonged by intense activity of mobile phones, social networks, the press and television.

### ***The elite and local healthcare systems***

One such fissure can be found between talk of prevention and real life. It concerns the inequalities that surfaced following the introduction of measures to stop the spread of the virus – measures which much of the elite, always quick to disregard common laws, spontaneously challenged. As a result, there were protests in Cameroon, for example, when a political leader returning from France did not self-isolate. Everywhere – including in Europe and notably in England with an incident involving an adviser to the Prime Minister – Covid-19 revealed practices differentiating the elite from the rest of the population. As remarked by Benin’s President Talon on 5 April with reference to the tens of billions spent on evacuating the privileged and before banning these evacuations paid for by the State: “People living in their village who don’t know anybody or are not close to power have no chance of being evacuated”. Covid-19 did not resolve any inequalities, but forced them to be voiced.

At the same time, this closure of the borders meant that some personalities, such as Pape Diouf in Senegal, were not able to be evacuated and shared the health plight ordinarily reserved for ordinary people. In another example, the death of the second Vice-President of Burkina Faso’s National Assembly in mid-March revealed a variety of dysfunctions in the health services, known to all, but brought out into the open by the social importance of those who suffered from them. To put it more broadly, “in the frontline when it comes to Covid-19, leaders are having to treat or protect themselves while trying to manage this crisis and hide their failures in the field of public health. In a way, they have been caught in their own trap, and this is a first”<sup>5</sup>.

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<sup>3</sup> « Covid-19 : l’Afrique en quête de réponses », *Le Point Afrique*, 16 mai 2020, [https://www.lepoint.fr/afrique/covid-19-l-afrique-en-quete-de-reponses-16-05-2020-2375737\\_3826.php](https://www.lepoint.fr/afrique/covid-19-l-afrique-en-quete-de-reponses-16-05-2020-2375737_3826.php)

<sup>4</sup> Gado Alzouma, « Téléphone mobile, Internet et développement : l’Afrique dans la société de l’information ? », *tic&société* [Online], vol. 2, n° 2, 2008, <https://journals.openedition.org/ticetsociete/488> ; « Jeunes et réseaux sociométriques en Afrique et en Haïti », Appel à contribution, *Calenda*, 1<sup>er</sup> février 2017, <https://calenda.org/392379>

<sup>5</sup> Jean-Paul Bado, in Joan Tilouine, « En Afrique, le coronavirus met en danger les élites dirigeantes », *Le Monde Afrique*, 3 avril 2020, [https://www.lemonde.fr/afrique/article/2020/04/03/en-afrique-le-covid-19-met-en-danger-les-elites-dirigeantes\\_6035384\\_3212.html](https://www.lemonde.fr/afrique/article/2020/04/03/en-afrique-le-covid-19-met-en-danger-les-elites-dirigeantes_6035384_3212.html)

**HUMANITARIAN ALTERNATIVES****Words, prevention measures and social inequalities**

Moreover, and more generally, on Thursday 7 May, WHO estimated that Covid-19 “could kill between 83,000 and 190,000 people in Africa in the first year and infect between 29 and 44 million” if no containment measures were put in place. Yet “containing” families living in “unplanned” neighbourhoods and forced to do some kind of work every day just to survive was quite simply impossible. In other words, the words used were the same everywhere, but had to be applied to very different realities. For the poorest, and in many countries and local situations, this globalised health narrative had no possible behavioural referents.

It became clear everywhere that the impact of preventive behaviours was determined by living conditions and social inequalities and that the economic consequences of the health measures weighed heaviest on the most vulnerable. This led to outbreaks of violence, especially in Senegal, by people for whom curfew went hand in hand with impoverishment. Those for whom, as always and according to their economic status and living arrangements, the health messages and protection proposals only meant greater hunger and increased vulnerability.

On the other hand, the existence of a dynamic informal market – born during the colonial era and strengthened by structural adjustment policies – accessed by a variety of vulnerable populations subsisting outside regulated and taxed economic systems<sup>6</sup>, resulted in the very rapid production of masks at affordable prices. Despite recommendations concerning certification however, nothing was standard and these masks – ranging from bits of cobbled-together fabric to rich fashion accessories designed to match people’s outfits – were as much a “symbolic” response to the fear of contamination and government requirements as a real means of health protection. It should also be said that people’s prompt willingness to cover their face was facilitated by existing habits, as in various socio-cultural groups, often for reasons of modesty, women’s veils and men’s turbans cover their nose and mouth. This social response, even though it was more of a sign than a real means of prevention, was also driven by families, which, after seeing pictures of events in Asia and Europe on the television, spontaneously adopted a form of “social distancing” as a precaution: masks, staying away from mosques and churches, etc.

Finally, as mentioned earlier, “for populations who have long had to cope with “unsociable medicine” and are highly critical of health providers, medical facilities did not suddenly become welcoming”<sup>7</sup>. The fragile, selective and non-egalitarian foundations on which health systems are built were not transformed by the epidemic. The landscape has stayed the same, but perhaps the epidemic has simply allowed us – obliged us – to say out loud what each of us has always known. To develop a truthfulness, a reflexivity, which, with the help of articles, narratives and critical testimony, prevents us from lying (to ourselves) overtly<sup>8</sup>.

**A health response founded on dignity**

These contradictions were – and still are – experienced locally. But, from abroad, the difficulties were an excuse for thinking of and describing Africa in terms of exclusively metonymic terminology, such as “vulnerable” and “region particularly at risk”. The different exchanges of opinion taking place and endogenous criticisms formulated in the *inter se* of societies thus came face to face with the exogenous discourse engaged in by others – humanitarian NGOs, journalists, scientific bodies – in which they first predicted a health disaster for Africa and then, as the health situation remained stable, explained why “in Africa, the predicted health disaster [had] not yet happened”<sup>9</sup>.

The words used in newspapers, articles, scientific papers, etc. to present their arguments may have differed, but these pejorative and “humanitarian” visions had something in common: they all made African

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<sup>6</sup> Jacqueline Damon, *L’Afrique de l’Ouest dans la compétition mondiale*, Karthala, 2003.

<sup>7</sup> Jean-Pierre Olivier de Sardan *et al.*, « Si l’Afrique veut être plus efficace face aux épidémies futures, elle doit tirer les leçons de ses insuffisances », *Le Monde Afrique*, 31 mai 2020, [https://www.lemonde.fr/afrique/article/2020/05/31/si-l-afrique-veut-etre-plus-efficace-face-aux-epidemies-futures-elle-doit-tirer-les-lecons-de-ses-insuffisances\\_6041339\\_3212.html](https://www.lemonde.fr/afrique/article/2020/05/31/si-l-afrique-veut-etre-plus-efficace-face-aux-epidemies-futures-elle-doit-tirer-les-lecons-de-ses-insuffisances_6041339_3212.html)

<sup>8</sup> Hannah Arendt, *La Vie de la pensée*, Payot, 1987.

<sup>9</sup> Title of the article by Simon Petite, *Le Temps*, 7 mai 2020, <https://www.letemps.ch/monde/afrique-catastrophe-sanitaire-annoncee-na-lieu>

## HUMANITARIAN ALTERNATIVES

States and populations into “objects” or “targets” of assistance rather than actors in their own destiny. And, for Africans, being dispossessed of themselves in this way was unacceptable. As highlighted by a group of researchers: “the reasons for having sounded the alarm reflect representations of Africa and its place in the world, between the habitus of catastrophism and the kind of intellectual sloth that expects to see and find Africa in the dead man’s shoes. As if, in the representations of the world, Africa is confined to the role of cradle of death and all the ills that cannot be cured without an external and “humanitarian” intervention”<sup>10</sup>.

These remarks echo those of Souleymane Bachir Diagne who pointed out that “Africa is not the demographic growth to which it is reduced by a good number of prospectivists and in which they see nothing but problems. It is a driver of innovation and creativity to which this vision of a rudderless Africa, lagging behind the rest of the world with which the only possible relationship is one of compassion does not do justice. [...] I [am] talking about the resilience and capacity to innovate of its young people, especially its urban youth [...]. All this speaks of countries which rely first and foremost on their own strengths and have the will and desire to put African intelligence to work”<sup>11</sup>.

Therefore, although this was evidently a health pandemic, through pages, reports and the words of “experts”, it was also about speaking out and pitting representations of Africa against other conceptions of itself. Health is always about more than just health and these controversies were an opportunity for some to express diverse forms of socio-political resentment<sup>12</sup> and, very generally, to refuse a kind of denial of consideration<sup>13</sup> clearly linked to the “geopolitics of emotion”.

This is also why, trapped in this globalised social representation of Africa<sup>14</sup>, the health choices made reflected a kind of “self-presentation” narrative developed for an audio-visual world that had turned the epidemic space into a means of scrutinising the conduct of “others” confronted with the virus.

This pandemic of everybody’s disease generated and intensified a globalised space for comparing the public policies implemented to control it. Consequently, in addition to addressing health requirements, the actions chosen were also used as a way of saying things to these other worlds that each State presumed were paying careful attention to its setbacks and successes. The result was a dual posture – although this dichotomy should be qualified. Internally, in the *inter se*, there was critical debate. But for the outside world, a common form of semantics was used evoking, in various ways, Africa’s ability to respond to the disease.

### **Refusal of research with Africa as a testing ground**

First of all, it was about refusing the proposals very “clumsily” – or pejoratively – presented by French practitioners and researchers on 3 April: “If I may be provocative, shouldn’t we be doing this study in Africa where there are no masks, no drugs, no life-support – a bit like is done elsewhere for studies on AIDS, or with prostitutes: we try things with them because we know they are highly exposed”<sup>15</sup>.

The responses to these comments were not “medical”<sup>16</sup>. They were political, evoking “colonial

<sup>10</sup> Laurent Vidal, Fred Eboko, David Williamson, « Le catastrophisme annoncé, reflet de notre vision de l’Afrique », *Le Monde Afrique*, 8 mai 2020, [https://www.lemonde.fr/afrique/article/2020/05/08/coronavirus-le-catastrophisme-annonce-reflet-de-notre-vision-de-l-afrique\\_6039110\\_3212.html](https://www.lemonde.fr/afrique/article/2020/05/08/coronavirus-le-catastrophisme-annonce-reflet-de-notre-vision-de-l-afrique_6039110_3212.html)

<sup>11</sup> « Souleymane Bachir Diagne : “L’Afrique bénéficie de sa confiance en la vie même” », *Le Point*, 30 avril 2020, [https://www.lepoint.fr/culture/souleymane-bachir-diagne-le-monde-entier-est-confronte-aux-memes-problemes-29-04-2020-2373526\\_3.php](https://www.lepoint.fr/culture/souleymane-bachir-diagne-le-monde-entier-est-confronte-aux-memes-problemes-29-04-2020-2373526_3.php)

<sup>12</sup> Pierre Ansart (dir.), *Le Ressentiment*, Bruxelles, Bruylant, 2002.

<sup>13</sup> Claudine Haroche et Jean Claude Vatin (dir.), *La Considération*, Desclée de Brouwer, 1998 ; Yves Déloye et Claudine Haroche (dir.), *Le Sentiment d’humiliation*, In Press, 2007.

<sup>14</sup> Arjun Appadurai, *Après le colonialisme*, Payot, 2015.

<sup>15</sup> « Coronavirus : un “vaccin testé en Afrique” ? Deux médecins font polémique sur LCI », *Le Parisien*, 3 avril 2020, <https://www.leparisien.fr/politique/coronavirus-un-vaccin-teste-en-afrique-deux-medecins-font-polemique-sur-lci-03-04-2020-8293419.php>

<sup>16</sup> Fred Eboko, « Non, l’Afrique n’est pas, ni de près ni de loin, la cible privilégiée des essais cliniques », *Le Monde Afrique*, 8 avril 2020, [https://www.lemonde.fr/afrique/article/2020/04/08/non-l-afrique-n-est-pas-ni-de-pres-ni-de-loin-la-cible-privilegiee-des-essais-cliniques\\_6035948\\_3212.html](https://www.lemonde.fr/afrique/article/2020/04/08/non-l-afrique-n-est-pas-ni-de-pres-ni-de-loin-la-cible-privilegiee-des-essais-cliniques_6035948_3212.html)

## HUMANITARIAN ALTERNATIVES

provocation” and “black (and poor) bodies [used as] a testing ground to save white [and rich] bodies”<sup>17</sup>. They obliged INSERM [France’s National Institute of Health and Medical Research] to apologise “to Africa” and the French Ministry of Foreign Affairs to distance itself from these comments that were also strongly condemned by the director of the World Health Organization: “The legacy of colonial mentalities must end. [...] It is shameful and horrifying to hear scientists make comments such as these in the 21<sup>st</sup> century. We condemn them in the strongest possible terms”<sup>18</sup>. The pain caused by abusive “compassion” was sharp; the wound inflicted by a lack of respect was deep<sup>19</sup>.

**Autonomous treatment choices**

As one would expect, at the local level the key decisions in response to the disease concerned treatment choices. Senegal, Burkina Faso, Morocco and Algeria all immediately adopted a treatment based on chloroquine, as this drug is affordable and already widely used on the continent for treating malaria. To take one example, Professor Moussa Seydi from Fann Teaching Hospital administered chloroquine to the first 100 patients to test positive for Covid-19 in Senegal and expressed an interest in Didier Raoult’s treatment as early 19 March 2020. And despite the caution published on 22 April by a college of doctors, notably African, on the inappropriate and generalised use of this treatment in Sub-Saharan Africa<sup>20</sup>, treatment choices have since remained the same, probably as much for economic as medical reasons, as well as a sort of socio-affective – or ideological – and professional choice, evoking “Raoult, the African”, his ancient family ties with Senegal and his constant scientific exchanges with West Africa. And it is also possible that the effectiveness of this treatment was seen as “a stroke of luck” for African countries, as these drugs are already available due to their use in malaria control.

This split on treatment choices between the North and the South was played up in the press. Europe, and France in particular, were described as places where confusion reigns over diverse “scientific studies”, with critics either disparaging the hesitations concerning treatment, or praising the appropriateness of the decisions made by WHO, while thinking vacillated on clinical findings and freedom of choices made by the African States. To take one example, the “epidemiologist” and biologist Cheikh Sokhna [...] has called *The Lancet’s* study “flawed”. He describes the work as “not very serious” and “biased”, carried out in record time by just four authors [...]. And what of WHO’s decision to suspend its trials? “Completely misguided”, according to the biologist. “It’s obvious that the laboratories are behind this study,” added Cheikh Sokhna, implying a “conflict of interest” on the part of the authors. This criticism has resounded throughout Africa where hydroxychloroquine, both available and inexpensive, is still the treatment favoured by the vast majority of health authorities<sup>21</sup>. The fights over treatment for people living with HIV are still very fresh in everybody’s minds: in addition to scientific reflection, the choice of treatment strategies remains a political act.

**Demands for recognition of “knowledge” and expertise**

With regard to coping with uncertainty and ensuring an effective response to the pandemic, the press and certain States have highlighted Africa’s experience. The epidemiologist Yap Boumhis drew attention to its empirical knowledge and to bodies of workers who have been seasoned by their constant fight against other epidemics: “Don’t forget that Africa is used to epidemics and has had to manage them without these technical solutions! Take Ebola! The community health workers are there, on the ground, they go from door-to-door. Imagine that all of sudden, in the village, people start having difficulty breathing and die. Do you think that people won’t know about it? The whole village will know! Africa has real experience of managing epidemics which is certainly of considerable use today”<sup>22</sup>.

<sup>17</sup> « Coronavirus : un “vaccin testé en Afrique” ?... », art. cit.

<sup>18</sup> « Coronavirus et essais de vaccin en Afrique : l’OMS fustige des propos “racistes” et une “mentalité coloniale” », TV5 Monde, 7 avril 2020, <https://information.tv5monde.com/afrique/coronavirus-et-essais-de-vaccin-en-afrique-l-oms-fustige-des-propos-racistes-et-une>

<sup>19</sup> Richard Sennett, *Respect. De la dignité de l’homme dans un monde d’inégalité*, Albin Michel, 2003.

<sup>20</sup> Pascale M. Abena et al., “Chloroquine and Hydroxychloroquine for the Prevention or Treatment of COVID-19 in Africa: Caution for Inappropriate Off-label Use in Healthcare Settings”, *The American Journal of Tropical Medicine and Hygiene*, vol. 102, 6, pp.1184-1188, <https://www.ajtmh.org/content/journals/10.4269/ajtmh.20-0290>

<sup>21</sup> Marième Soumaré, « L’hydroxychloroquine toujours plébiscitée en Afrique, malgré les controverses », *Jeune Afrique*, 30 mai 2020, <https://www.jeuneafrique.com/990170/societe/lhydroxychloroquine-toujours-plebiscitee-en-afrique-malgre-les-controverses>

<sup>22</sup> Claude Guibal, « Face à la Covid-19, comment s’en sort (vraiment) l’Afrique ? », *France Culture*, 11 mai 2020,

## HUMANITARIAN ALTERNATIVES

Another way of presenting a sort of African specialisation and its place in globalised therapeutic research circles has been to invoke, in the name of a certain “African identity”, various treatments described as “traditional knowledge” or consisting in “local pharmacopoeia” and presented as effective therapeutic responses. Some of the products from this local pharmacopoeia, such as Fagaricine, discovered by the Gabonese Bruno Eto, have been recommended as treatments for immunodeficiency in patients. Apivrine, invented by the Beninese Valentin Agon, is presented as a radical treatment for Covid-19<sup>23</sup>. As is Covid-Organics, officially launched in Madagascar on 20 April by the country’s president, recommended and massively prescribed on the island and disseminated over the entire African continent. “Chad has used it with success”, for example, with 34 patients “cured” by this treatment<sup>24</sup>.

These treatments and products have generated much debate. But here again, health care and politics were mixed with commercial issues to offer something “local” – or an “identity” even – as a counter to scientific modernity which can only be borrowed from elsewhere. And many newspapers have relayed this antiphony with no attempt to qualify it. In Senegal: “This typically “Made in Africa” product, which represents a serious threat to international pharmaceutical groups, is creating a buzz on social media as, for Africans, it reflects our capacity to create, innovate, invent and impose a product that is 100% local. A way of restoring Africa’s pride, long undermined by the West. Far from the usual clichés, Africa has a bright future ahead. With an average age of 20 years (the youngest continent) and only 1.3% of the world’s cases of Covid-19 contamination, and now with an increasingly well-trained scientific community. Africans are justified in believing in their continent, and consequently in their Covid-Organics”<sup>25</sup>. And on the Island of Reunion: “After the Democratic Republic of Congo, Senegal is now asking for Covid-Organics, refuting information to the contrary disseminated by certain western media outlets. And so is Guinea Bissau. This improved version of a traditional remedy strengthens the immune system, giving the body the means to fight back against the coronavirus. If African leaders are enthusiastic about it, so is the population! In addition to the expectations surrounding this remedy, Covid-Organics would appear to confirm the existence of a deeply felt sentiment – the need to free Africa from neo-colonialism. Researchers at IMRA [Madagascan Institute of Applied Research] and the Madagascan government have reminded us that Africa has considerable potential for development, and many Africans are proud to see that the first coronavirus-specific remedy comes from Madagascar. This message should serve as a reality check: we should be proud to be African”<sup>26</sup>.

As mentioned earlier, these “remedies” have been the subject of much heated debate. Various healthcare providers and African researchers have demanded that proper scientific procedures be used to evaluate these treatments and cautioned people against an overly close association of commercial interests with unproven therapeutic claims. These same scientists, along with various medical teams such as the Institut Pasteur of Dakar, despite various controversies emanating from French “conspiracy theorists”, have highlighted their substantial scientific expertise. Other institutions have demonstrated their technical know-how by producing hydroalcoholic gel (Universities of Dakar, Saint Louis and Ziguinchor) or prototypes of ventilators and automated hand-washers (École polytechnique in Thiès).

These stances, ranging from the “traditional” to the scientific are very different, opposed even. But, in the media, they have been narrated in the same way, linking research to identity claims. “Side-lined yet again from the international clinical research being conducted to unravel the mysteries of Covid-19 and find a remedy and a vaccine, African researchers are willing to fight to be heard”, claims *Jeune Afrique*<sup>27</sup>, echoed by *Le Monde Afrique* which, on 22 May, praised, “these eleven African men and women who are helping to

<https://www.franceculture.fr/sciences/face-au-covid-19-comment-sen-sort-vraiment-lafrique>

<sup>23</sup> Marième Soumaré, « Coronavirus : les chercheurs africains veulent se faire une place dans le club fermé de la recherche mondiale », *Jeune Afrique*, 28 avril 2020, <https://www.jeuneafrique.com/933572/societe/coronavirus-les-chercheurs-africains-veulent-se-faire-une-place-dans-le-club-ferme-de-la-recherche-mondiale>

<sup>24</sup> Albert Savana, « Le covid-organics de Madagascar face aux réserves de l’OMS », *Finacial Afrik*, 10 juin 2020, <https://www.finacialafrik.com/2020/06/10/le-covid-organicsde-madagascar-face-aux-reserves-de-loms>

<sup>25</sup> Tidiane Diouwara, « Remède contre le COVID-19 : et si la solution venait d’Afrique ? », *Le Temps*, 8 mai 2020, <https://blogs.letemps.ch/tidiane-diouwara/2020/05/08/remede-contre-le-covid-19-et-si-la-solution-venait-dafrique>

<sup>26</sup> *Ibid.*

<sup>27</sup> Marième Soumaré, « Coronavirus : les chercheurs africains... », art. cit.

contain the pandemic on their continent”<sup>28</sup>. Whatever the rhetoric, however it is presented, the ability to heal always rhymes with pride.

### **The pandemic: caught between the need to manage a health risk and to respect dignity**

The pandemic, in addition to its strictly medical characteristics, has undoubtedly been the first event to construct a social self-presentation space on a global scale, combining a complex narrative universe, a system for the circulation of emotions – notably fear<sup>29</sup> – and a space for the comparison of health policies.

In health terms, there is a risk that this “technological exposure of self”<sup>30</sup> or these “identity reconstruction tools”<sup>31</sup> will lead to an over-reaction to the event or the recommendation of measures that we know cannot be applied in certain local contexts. This can also lead to adopt a sort of globalised health narrative, such as on lockdown or the closing of borders, for which no frame of reference is possible and, in doing so, cause the neglect of other health domains that receive less media attention and therefore, it must be said, are less immediately lucrative.

The epidemic is still here and it is difficult to predict how a health and economic situation in Africa, that depends on a multitude of factors and the conduct of a range of stakeholders, is going to progress. We believe, however, that the African response to the pandemic – at least in its current state – can be characterised by three attitudes.

First of all, a desire to be an actor in the research, as well as in the solutions to be brought to this epidemic. The Kenyan pulmonologist, Evans Amuyoke, expresses this perfectly when he says that he hopes Africa will eventually “have a seat at the discussion table” of research on Covid-19. And that “it is important for us to be not just consumers of knowledge, but part of the group that creates this knowledge”<sup>32</sup>. Then comes a desire to choose health policies independently and, as said by Michel Sidibé, Mali’s Minister of Health, not neglect other diseases: AIDS, cancers – especially cervical cancer – and all the chronic diseases, such as sickle cell anaemia and diabetes<sup>33</sup>. The global must not be allowed to overshadow the local. Lastly, we should stress that these health debates are an intrinsic part of these socio-political reconfigurations, combining the desire for economic and monetary independence and the demand for respect for people on a worldwide scale (*black lives matter*).

These notions may seem diverse, but the narrative frameworks explaining human action that are currently circulating on the social networks and in the media are uniting these different forms of globalisation into a single demand. Thus, we cannot imagine world health without respect for the dignity of those who must implement it, nor understand certain health choices without also understanding the social issues at play.

*Translated from the French by Mandy Duret*

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### **Biographies**

**Yannick Jaffré** • Anthropologist, emeritus research director at France’s National Centre of Scientific Research

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<sup>30</sup> Mahdi Amri et Nayra Vacafior, « Téléphone mobile et expression identitaire : réflexions sur l’exposition technologique de soi parmi les jeunes », *Les Enjeux de l’information et de la communication*, vol. 2010 (1), p. 1-17, <https://www.cairn.info/revue-les-enjeux-de-l-information-et-de-la-communication-2010-1-page-1.htm>

<sup>31</sup> Cédric Fluckiger, « Blogs et réseaux sociaux : outils de la construction identitaire adolescente ? », *Diversité*, n° 162, 2010, p. 38-43.

<sup>32</sup> Marième Soumaré, « Coronavirus : les chercheurs africains... », art. cit.

<sup>33</sup> Michel Sidibé, « Hormis le Covid-19, d’autres pathologies sont tueuses en Afrique », *France 24*, 26 mai 2020, <https://www.youtube.com/watch?v=POmobwLFTYo>

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(CNRS-UMI 3189 Environment, Health and Society) and scientific director of GID-Santé (Inter-academic Group for Development – Health) at the Académie des Sciences – Institut de France. Yannick Jaffré lived in the Sahel for twenty years where he taught at several faculties of medicine and conducted various studies on the anthropology of the body, health and sensitivities. His research focuses mainly on maternal, child and neonatal health.

**Hélène Kane** • Hélène Kane is a Doctor of Health Anthropology, associate researcher at the Environment, Health and Societies International Joint Unit (CNRS-UMI ESS) (France) and project manager for the Société française de santé publique [French Society of Public Health]. She has conducted research on childhood, representations of diseases and access to and quality of healthcare in several West African countries. She is currently coordinating a research project on community health in partnership with Unicef.

**Fatoumata Hane** • Social anthropologist, senior lecturer at Assane Seck University, Ziguinchor (Senegal) and researcher at UMI 3189 Environment, Health and Society, Fatoumata Hane has conducted studies on health systems and policies in Africa, professional reconfigurations in health and the place of children in paediatric care systems. She has also worked on ageing in Senegal and in the context of migration and on gender-based issues. Her research focuses mainly on health policies and health governance.

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## HUMANITARIAN ALTERNATIVES

*Reproduction prohibited without the agreement of the review Humanitarian Alternatives. To quote this article:*  
Yannick Jaffré, Hélène Kane, Fatoumata Hane, “A test of dignity: an anthropological analysis of Covid-19 responses in West Africa”, *Humanitarian Alternatives*, n°14, July 2020, p.96-113,  
<http://alternatives-humanitaires.org/en/2020/07/23/a-test-of-dignity-an-anthropological-analysis-of-covid-19-responses-in-west-africa/>

ISBN of the article (PDF): 978-2-37704-691-1