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Global Public Health
An International Journal for Research, Policy and Practice

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Mariam O. Fofana (2021) Decolonising global health in the time of COVID-19, Global Public Health, 16:8-9, 1155-1166, DOI: 10.1080/17441692.2020.1864754

To link to this article: https://doi.org/10.1080/17441692.2020.1864754

GLOBAL PUBLIC HEALTH
2021, VOL. 16, NOS. 8–9, 1155–1166
https://doi.org/10.1080/17441692.2020.1864754

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Decolonising global health in the time of COVID-19

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ABSTRACT

The persistent influence of coloniality both from external actors and from within threatens the response to COVID-19 in Africa. This essay presents historical context for the colonial inheritance of modern global health and analyses two controversies related to COVID-19 that illustrate facets of coloniality: comments made by French researchers regarding the testing of BCG vaccine in Africa, and the claims by Madagascar's president Andry Rajoelina that the country had developed an effective traditional remedy named Covid-Organics. Leveraging both historical sources and contemporary documentary sources, I demonstrate how the currents of exploitation, marginalisation, pathologisation and saviourism rooted in coloniality are manifested via these events. I also discuss responses to coloniality, focussing on the misuse and co-optation of pan-Africanist rhetoric. In particular, I argue that the scandal surrounding Covid-Organics is a reflection of endogenised coloniality, whereby local elites entrench and benefit from inequitable power structures at the intersubjective (rather than trans-national) scale. I conclude with a reflection on the need for equity as a guiding principle to dismantle global health colonialism.

ARTICLE HISTORY
Received 12 October 2020
Accepted 2 December 2020

KEYWORDS
COVID-19; Africa; colonialism; decolonising; global health

Introduction

The persistent influence of coloniality both from external actors and from within threatens the response to COVID-19 in Africa. As recently as August, US media outlets reported that scientists were 'puzzl[ed]' that African countries did not experience a more severe toll from COVID-19 (Nordling, 2020), trafficking in the implicit assumption that they were expected to fail. As wealthy countries scramble and outbid each other to guarantee a supply of newly developed vaccines, Africa risks again being left behind, unless the global community commits to equitable access to this eagerly awaited salve (Oltermann, 2020; Usdin, 2020). In addition to these external threats, African countries must also contend with those from within, as was the case with the embezzlement of funds and supplies earmarked for the COVID-19 response in Kenya (NTV Kenya, 2020).

The events surrounding the ongoing pandemic of COVID-19 offer a timely lens through which we can examine the persistent influences of colonialism and coloniality in the field of global health. The paper begins with a review of the history of modern global health in order to elucidate the aspects of colonialism that have become embedded in the field. I then turn my attention to controversial comments made by French researchers regarding conducting vaccine trials in Africa, and demonstrate how they reflect persistent colonial attitudes. Next, I briefly discuss responses to colonialism, focussing on pan-Africanism as a decolonial movement. This discussion lays the ground

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for an analysis of the controversy surrounding the promotion of Covid-Organics, and situates it within the discourse of (anti)colonialism. Finally I offer reflections on a path towards decolonising global health.

Historical development of global health

The roots of our discontent

I will begin by briefly reviewing the colonial origins of modern global health. The late nineteenth century marked a period of aggressive colonial expansion by European nations, during which rival colonial powers divvied up the continent's territories amongst themselves. Despite being economic competitors, these nations were all involved in what they perceived as a 'civilizing mission' (Neill, 2012, p. 13) to the people whom they colonised. During the same period, new scientific insights into the microbiological basis of many diseases by the likes of Robert Koch and Louis Pasteur revolutionised the field of medicine. The convergence of these developments would give birth to what was alternatively termed tropical or colonial medicine, a field that grew out of the need to tame diseases that sickened the colonial administrators sent to distant shores as well as the local populations whose labour they exploited. Its early disciples were driven to identify the pathogens responsible for such scourges as malaria and sleeping sickness, which had earned tropical Africa the moniker of 'white man's grave' (Curtin, 1961), and to develop treatments for them (Neill, 2012, pp. 13–19).

This new branch of medicine served as the 'more beneficent' (Neill, 2012, p. 19) face of the otherwise brutal colonial regimes that it helped sustain. If there was any doubt about the true purpose of tropical medicine, the early funders of the institutes where the discipline flourished were clear about their motives: their support was an 'investment' (Neill, 2012, p. 23) that was expected to eventually yield greater profit. Physicians themselves recognised that 'participation in colonial medicine was vital because the success of European colonization depended on health' (Neill, 2012, p. 25). Most doctors dispatched to colonies were trained in institutes in the metropolitan centres of Europe, where they had little access to patients with the diseases that they would be tasked to treat on their missions. Indeed, colonial medicine was very much a discipline whose intellectual centre was in Europe, but that was meant to be practiced elsewhere, on distant and foreign people (Neill, 2012, pp. 19–44).

Tropical medicine not only operated in the service of colonial exploitation, it was itself an exploitative practice. In her study of medical research in African colonies, historian Helen Tilley (2016) notes that there were few, if any ethical standards for research in the colonial era. Physicians dedicated to researching and controlling sleeping sickness engaged in mass forced displacement, unnecessary procedures, and administration of highly toxic drugs, yet likely viewed themselves as saviours, advancing science and saving vulnerable populations that could not otherwise protect themselves from disease.

Tropical medicine was also steeped in racist beliefs, for instance that 'different diseases attacked different races' (Neill, 2012, p. 66): some physicians believed that Africans were particularly resistant to heat, blood poisoning and cancer, while Europeans were prone to 'tropical neurosis' or 'soudanite', a mental affliction brought on by the environmental conditions of the tropics, to which natives were of course immune (Neill, 2012, p. 68). Colonised people were deemed backwards and in desperate need of the civilising and modern influence of Europe. The discipline was deeply invested in racist beliefs regarding physiological differences, which were the presumed cause of differences in susceptibility to diseases between local populations and colonial transplants (Neill, 2012, pp. 66–73). There were deliberate efforts to marginalise, and even criminalise indigenous healing practices (Tilley, 2016). The post of physician was initially limited to Europeans, and even as these restrictions loosened, access to full medical education remained limited for Africans in the colonies (Monekosso, 2014; Neill, 2012, p. 61).

The international health era

In the early twentieth century, the fight against tropical diseases that had been the hallmark of colonial medicine was joined by philanthropic institutions such as the Rockefeller Foundation under the banner of *international health*. Despite the change in name, the leitmotiv of a 'civilising' mission remained the same, with the added benefit of protecting investment in regions that provided raw materials for capitalist enterprises and accruing political goodwill. In fact, the imprimatur and influence of colonial authorities were instrumental in some of the Foundation's early hookworm eradication initiatives in the Americas. Imbued with the same sense of beneficent paternalism that had justified the civilising mission of colonial powers, the new wave of international health experts sought to implement technological solutions with little input sought from local populations or attention paid to communicating with them. Their modus operandi betrayed disdain for the autonomy, self-determination, and cultures of the recipients, reflected in the assumption that when they rejected the interventions offered by their would-be benefactors, it was because they were ignorant or uncultured—or even reckless. Samuel Taylor Darling, who was involved in the Rockefeller Foundation's hookworm eradication initiative, described the Tamil workers who were the purported beneficiaries of his efforts as '"ignorant, superstitious, and servile, […] incapable of administering their own affairs, with either dispatch or intelligence"' (Darling, 1920, as cited in Packard, 2016, p. 37).

The era of international health largely retained what I refer to as a saviourism mindset, rooted in the belief that whatever intervention one implements is better than nothing, so destitute and bereft of options are the recipients of the purported aid. This is the attitude that allowed the physicians in charge of disease eradication programs in the early twentieth century to recommend mass treatment with the highly toxic but cheaper Chenopodium oil (with side effects including 'a semicomatose state' and 'deafness') for the treatment of hookworm instead of less toxic options (Packard, 2016, pp. 38–39). As historian Randall Packard (2016) sums it up, 'disease-control strategies forged initially in the crucible of colonial rule during the first decades of the twentieth century […] became central to the practices of international health' (p. 43). The lasting influence of these approaches and attitudes was likely at least partly a result of the fact that the Rockefeller Foundation was the driving force behind the establishment of some of the first schools of public health in the United States, which continue to wield enormous influence on today's global health landscape (Packard, 2016, pp. 41–43).

A troublesome inheritance

The emergence of new disease threats in the 1990s (chiefly HIV/AIDS) and the growing trend towards globalisation of markets and societies ushered in the current era of global health. But was this truly a departure from the prior era of international health? This term recognised the growing interconnectedness of the world and the sense that 'plagues were no longer limited to the populations of underdeveloped countries' (Packard, 2016, p. 273). It was also a nod to the forces of globalisation and neoliberalism that shifted significant influence to organisations such as the World Bank and International Monetary Fund, motivated by the belief that 'diseases like AIDS and malaria were a major drain on the economic development of resource-poor countries' (Packard, 2016, p. 274). Here again, in the 1990s as 100 years prior, the improvement of health served to buttress economic motives.

The term *international health* naturally begs the question: international with respect to whom? The implied answer is that the points of reference are former colonial powers of Europe, as well as countries like the United States that, although they claimed fewer overseas colonial possessions, have emerged as leading neo-colonial powers, exerting unrivalled political and economic influence in the era of global capitalism (Mpofu & Ndlovu-Gatsheni, 2019). In contrast, *global health* evokes a sense of unity and interdependence, shifting the emphasis from unidirectional interventions (from First to Third World, from former colonial powers to formerly colonised nations).

Yet, despite its seemingly more inclusive appellation, the intellectual, financial, and political centres of global health remain firmly ensconced in the First World. For instance, analyses of authorship in health research have found patterns that mimic old colonial relationships and perpetuate the marginalisation of African voices. A bibliographical analysis of 'collaborative' health research conducted in Africa found that, of over 7000 articles, the first author was affiliated with an institution in the country where the research was conducted in only 52.9% of cases. That is, even in a subset of publications based on collaborative projects in Africa, barely half give primary scientific credit to African researchers. This representation was lower when the research was conducted in collaboration with authors from the USA, Canada or Europe, compared with collaboration with authors from other African countries. The authors conclude that authors from African institutions often ended up 'stuck in the middle', getting neither the credit for primary intellectual input that comes with first authorship, nor the credit for intellectual leadership and supervision that is associated with senior (last) authorship. As many as 13.5% of papers had no authors with affiliations in the country of research focus (Hedt-Gauthier et al., 2019). Similarly, in a systematic review of authorship in infectious disease research conducted in African countries, the authors found that less than half of the nearly 1200 articles had an African first or last author, and 85 had no African author at all (Mbaye et al., 2019). This phenomenon has been summed up by Reidpath and Allotey (2019) as 'trickle-down science', directed by the Global North and conducted in the Global South, but sometimes poorly aligned with the purported beneficiaries' needs and priorities.

In short, while being *exploited* as a source of research subjects and data, Africa remains *marginalised* as a source of knowledge and innovation. The raw materials for research are extracted from Africa but the resulting academic wealth (in the form of authorship, recognition, awards, and funding) flows disproportionately to institutions in the colonial powers of old, in a stark parallel to other extractive industries that sustain economic colonialism decades after the formal end of juridical colonisation. Global health has remained largely, as Packard (2016) suggests in the title of his book, about 'interventions into the lives of other people'.

The global health era clearly inherited some of the cultural baggage of its predecessors, as demonstrated by the PEPFAR program's insistence on the ABC (Abstinence, Be faithful, Condoms) strategy, which bought into the racist/colonial trope of African and Black people as over-sexed, and thus approached the HIV epidemic in Africa as a problem driven by hazardous behaviours rather than aiming to unroot the structural factors that made people vulnerable to disease. Here again, we see the colonial pattern of pathologising the behaviours of the populations targeted by these interventions. Though it must be acknowledged that the current era of global health has brought about increased awareness of social determinants of health and equity, there remain shocking parallels to the practices of colonial medicine. Just as settler women with no training engaged in amateur medicine in British colonies (Wells, 2018), as recently as 2015, a young American woman was exposed for practicing medicine without training at a missionary centre in Uganda (Aizenman & Gharib, 2020). The currents of saviourism are alive and well.

Colonialism in action

On April 1 2020, French news channel LCI broadcast an interview by Dr Jean-Paul Mira, head of intensive care at the Cochin Hospital in Paris, of Dr Camille Locht, head of research at the French national institute of health research (Institut National de la Santé et de la Recherche Médicale, INSERM) discussing ongoing trials of the BCG vaccine as a potential preventive intervention against COVID-19 that were being conducted in Europe and Australia. At one point in the interview, Mira asks whether such studies 'should not be conducted in Africa, where there are no masks, no treatments, no intensive care', drawing an analogy to HIV studies conducted among commercial sex workers who 'are highly exposed and do not protect themselves'. Locht enthusiastically agrees, noting that his team was indeed considering conducting a parallel trial in Africa (TRT World Now, 2020).

The segment was disseminated on social media networks, where it promptly drew the ire of African users in particular. I would argue that the suggestion of conducting such a trial in Africa was scientifically flawed, as the hypothesis was based on ecological studies that are highly susceptible to confounding effects; moreover, most Africans receive BCG vaccination in childhood, and the suggested trial should ideally be conducted in a setting with low pre-existing exposure to BCG (Zwerling et al., 2011). These scientific faults were eclipsed by backlash over the disparaging tone with which Locht referred to commercial sex workers, and outrage at the idea of exploiting Africa as a 'testing lab' for research (Drogba, 2020). Prominent figures such as footballers Didier Drogba of Côte d'Ivoire and Samuel Eto'o of Cameroon took to social media networks to condemn the comments as racist, and the story quickly spread to global news outlets (Drogba, 2020; Eto'o, 2020). A few days later, Dr Tedros Ghebreyesus, the first African to serve as director general of the World Health Organization (WHO), also decried the comments as reflective of a 'colonial mentality' (World Health Organization, 2020).

What is remarkable about this conversation is that in just a few sentences, it manages to illustrate several key features and accepted norms of medical colonialism. When Mira suggests that the study should be conducted in Africa, he exhibits the same *exploitative* drive of colonial-era physicians who saw Africa and Africans as a source of raw material for research that would further their careers. The familiar refrain of *saviourism* is evident in Mira's assertion that the rationale for conducting a study in Africa is that the continent is devoid of resources—'no masks, no intensive care'—such that any intervention should be viewed as a charitable and commendable act. Mira then compares the situation of Africans facing the COVID epidemic to sex workers and the HIV epidemic, implying that both groups 'do not protect themselves'. Again, this framing that *pathologises* the actions and habits of the target population, positing that the susceptibility to illness derives from a behavioural failing, harkens back to the attitudes of colonial physicians who looked with contempt upon the people on whom they imposed their interventions. This tendency to pathologise the culture and/or behaviours of a group is what Ibram Kendi describes as 'cultural racism', the creation of a cultural hierarchy among racial groups (Kendi, 2019, pp. 82–91).

Locht's response is interesting, primarily in that he seems oblivious to the problematic aspects of Mira's suggestions. In fact, after the initial uproar on social media, Mira, Locht and their institutions initially attempted to justify their stance and dismiss the backlash and accusations of racism as 'fake news' (INSERM, 2020). Indeed, when one considers these comments without regard for the underlying historical context of systematic exploitation, pathologisation, and saviourism that pervaded colonial medicine, they might seem reasonable. Locht's response betrays how deeply embedded colonial attitudes are to this day, so much so as to become nearly invisible to the uncritical mind. It is not by chance that the most prominent denouncements came from Africans such as Drogba, Eto'o and Ghebreyesus. Indeed, those who have suffered under political colonialism and continue to suffer under the weight of neo-colonial domination are the most astute observers of these forces.

Locht and Mira conjured up the ghosts of colonial physicians who pathologised the culture and customs of local populations and unilaterally imposed interventions, yet perceived themselves as benevolent saviours rather than as participants in an oppressive and exploitative system. It seemed inconceivable that such 'colonial' attitudes would be so openly espoused in the year 2020. Yet, as I have demonstrated here, far from being an anomaly, such attitudes are a deeply embedded common thread persisting from the age of colonial medicine to the current era of global health. It is essential to understand the ways in which these colonial attitudes continue to shape the practice of medicine and research so that we may exorcise them. Locht, Mira, and their respective institutions eventually presented public apologies but some of the damage that they have caused cannot be undone (Singh, 2020). Beyond the direct effects of fostering suspicion of vaccines against SARS-CoV-2, the justified fear of being exploited and being used as a 'guinea pig' (Drogba, 2020) will likely help to bolster anti-vaccine sentiment in general and further discourage participation in the kind of ethically conducted research that is necessary to remedy health inequities.

(De)coloniality and pan-Africanism

Locht and Mira's comments provide a strident illustration of the distinction between juridico-political *colonisation*, which ended in the mid to late twentieth century in Africa, and the phenomenon of *coloniality*, which continues to thrive. Anthropologist Eugene Richardson sums up coloniality as 'the matrix of power relations that persistently manifests transnationally and intersubjectively despite a former colony's achievement of nationhood', the 'hierarchical orders imposed by European colonialism that have transcended "decolonization" and continue to oppress' (Richardson, 2019). This matrix of power continued to operate, if not in the form of direct institutional control, via economic and cultural dominance, in what Kwame Nkrumah coined 'neo-colonialism' (Nkrumah, 1984). Neo-colonialism 'reinforces the colonialist paradigm of control and influence through [often] unrecognized actions, behaviours, attitudes and beliefs' (Eichbaum et al., 2020). Thinkers like Nkrumah wisely saw that colonialism/coloniality went far beyond political and economic power, and they recognised the 'mental colonization' that sustained the enduring patterns of power, dominance, and dependence. They recognised that, beyond the official removal of colonial power, there was a need for 'decolonization of the mind that made the coloniser feel superior and the colonized feel inferior' (Eichbaum et al., 2020). Decolonial thinking or practices thus refer to efforts to 'understand, in order to overcome, the logic of coloniality' that is often embedded and implicit in the structures of our societies, with the ultimate aim of dismantling the 'colonial matrix of power' (Mignolo, 2011, pp. 1–24).

In the African context, opposition to political colonialism and the more insidious, enduring wounds of coloniality were intimately entangled with the ideals of pan-Africanism. The philosophy of pan-Africanism is at its core one of liberation. The term first emerged among (formerly) enslaved people in the Americas, who appealed to the shared African origins of victims of racism and slavery so that they may join forces in their common struggles. The idea found new life in the early twentieth century as a rallying cry for Africans seeking independence from colonial powers (Malisa & Nhengeze, 2018). Political leaders of this era, including Nkrumah, saw the battle for independence as a shared struggle among African nations and worked together despite differing in their views of the forms of government and economic structure that their countries should adopt (Biney, 2011, pp. 173–191). Pan-Africanism appeals not only to solidarity, but also to a revalorisation of African culture, a reversal of centuries of denigration, marginalisation, and erasure. It is a movement of 'African cultural rebirth and revival that reflects integrity and pride in self, culture, history', and empowers Africans to '[set] the terms of their own social development' (Sefa Dei, 2012). It is neither my goal nor my intention to delve into the merits or failures of pan-Africanist movements here, but simply to provide the necessary context to understand how the rhetoric of pan-Africanism and anti-colonialism was exploited for suspect ends, as I demonstrate in the following section.

The curious case of Covid-Organics

Before the brouhaha over Locht and Mira's comments had even died down, on April 19, 2020, Andry Rajoelina, president of Madagascar, took to the social media platform Twitter to announce that the country had developed an artemisia-derived traditional remedy against COVID-19, with both preventive and curative properties; the remedy would be mandatory for students returning to school (Rajoelina, 2020a, 2020b). The announcement was met with appropriate scepticism, as it came unsupported by any data describing the research that might have led to the development of this remedy and demonstrated its efficacy. In a curious turn of events, the Malagasy academy of medicine (Académie Nationale de Médecine de Madagascar) released a letter warning against the use of the remedy, suggesting that as suspected, it was hardly the fruit of a rigorous research process but rather a feat of quackery (Midi Madagasikara, 2020). Similarly, the WHO released a statement with an oblique reference to Covid-Organics, advising that 'caution must be taken against misinformation, especially on social media, about the effectiveness of certain remedies' (WHO

Regional Office for Africa, 2020). Undeterred by these rebukes, Rajoelina began sending shipments of Covid-Organics to other African countries, congratulating himself on this show of solidarity (Rahagalala, 2020a; Rajoelina, 2020c, 2020d). In a televised interview, Rajoelina responded to nay-sayers by stating that scepticism about the remedy was due to anti-African bias (Radio France Internationale & FRANCE 24, 2020). In effect, he blamed colonial attitudes that devalue local knowledge while holding Western science as the gold standard, for putting down what should have been hailed as a wonderful achievement. In his defence of Covid-Organics, Rajoelina echoed the sentiment expressed by Fela Kuti in his song *Colonial Mentality*: 'De ting wey black no good / Na foreign things them dey like' (Kuti, n.d.).

On its surface the development of Covid-Organics may appear to be a prime example of decolonising health research: Malagasy scientists leveraging indigenous knowledge and resources by developing a remedy from the local traditional pharmacopeia. But scratching the surface, something more insidious reveals itself. A little over two months after Rajoelina's initial announcement, Madagascar had experienced a surge in COVID-19 cases that filled its intensive care units to capacity (AfricaNews, 2020; Rahagalala, 2020b). Eventually, a study conducted by the Nigerian National Institute of Pharmaceutical Research and Development would find that Covid-Organics had no curative effect as Rajoelina had claimed (Sahara Reporters, 2020). Although Rajoelina's promotion of Covid-Organics may be at an opposite end of the spectrum from Locht and Mira's comments, I argue that both events were in fact manifestations of coloniality.

Amílcar Cabral, leader of the independence movement in Guinea-Bissau and Cape Verde, warned against the perpetuation of colonialism after African countries achieved political independence. Cabral recognised that Africans who were among the elite of their countries derived benefits from the colonial structure entrenched within newly decolonised states and societies. Rather than pursuing the struggle to dismantle these structures, elites have often been tempted to 'endogenise' them, that is, recast them in national(ist) trappings, to consolidate their power and privileges. In many countries, the ruling classes maintained and enforced colonial laws that had been used to repress activities and practices deemed threatening to the colonial state. In this way, colonial censorship statutes, laws on sedition and the repression of sexual practices viewed as deviant were all redeployed to defend the honour and stability of the newly independent states and their ruling class (Oyěwùmí, 1997, pp. 121–156; Prempeh, 2013; Rodriguez, 2017). In Cabral's view, the 'petite bourgeoisie [..] assimilate[d] the colonizer's mentality', and in seeking to consolidate its social privileges, failed to advance the liberation of the majority of the population over whom they would come to rule (Cabral, 1974). Cabral thus makes evident that coloniality exists beyond the temporal bounds of colonisation, and that (formerly) colonised subjects can in fact be crucial agents in the reproduction of colonial power structures. In effect, a local elite class that works to entrench intersubjective power dynamics and inequities, even as they may appear to rebuke such power dynamics at the trans-national level, traffic in a covert form of coloniality.

Indeed, Rajoelina's actions fit a pattern of entrenching the marginalisation of those at the bottom of societal hierarchies. By selling the illusion of protection, Rajoelina likely lulled the consumers of Covid-Organics into a false sense of security, and implicitly relieved the government of its responsibility to implement adequate screening, treatment, and distancing measures that could slow the spread of the epidemic. Those who are most likely to not only contract COVID-19 but also suffer the most morbidity and mortality from it are the poor who lack adequate access to care. If Rajoelina were to be stricken with COVID-19, he, unlike ordinary citizens, would likely have access not only to the best medical facilities and experts available within Madagascar, but could even jet away to receive treatment abroad as so many other African presidents and politicians have, even despite extensive travel restrictions (FRANCE 24, 2020; Jeune Afrique, 2020; Olaniyi, 2020).

In peddling what he claims is a traditional remedy, Rajoelina portrays himself as a defender of tradition, but is in fact exploiting the idea of tradition for political gain in a similar manner as colonists did a century prior. Colonial authorities exploited the notion of tradition to prop up 'native'

leaders who were portrayed as representatives of local customs and populations but in fact were intermediaries of colonial rule. This is the case, for example, of British colonists in India, who reinforced the caste hierarchy and relied on higher-caste groups as intermediaries (Dirks, 2001, pp. 149–172; Mamdani, 2018, pp. 37–61). In his television interview, when asked whether he has evidence of the efficacy of Covid-Organics, Rajoelina claims that, as a traditional remedy, it neither needs to be nor should be evaluated with clinical trials as most medications are (Radio France Internationale & FRANCE 24, 2020). Rajoelina's stance that modern scientific methods are not applicable to this traditional remedy appeals to the notion that tradition is static and inert rather than alive and ever-evolving, that tradition exists in opposition to modernity rather than in conjunction with it, that African knowledge is inherently non-scientific. This view echoes the colonial idea that what is African or traditional is incompatible with modernity and progress.

Rajoelina's actions were particularly pernicious as he hijacked the language of anti-colonialism and pan-Africanism but in the end, the promotion of claims that were unlikely to be substantiated perversely served to devalue the repute of indigenous healing traditions and reinforce the perception that African countries cannot generate valuable scientific advances, thus abetting the marginalisation of African knowledge. Of course, fraudulent or exaggerated claims are not an exclusively African phenomenon. In fact, the science of COVID-19 has been fraught with scandals ranging from unsubstantiated claims such as those made by Didier Raoult regarding hydroxychloroquine and azithromycin (Retraction Watch, 2020a), to outright fraud in the case of Surgisphere's fabrication of data in a prominent and highly mediatised study (Retraction Watch, 2020b). Rajoelina's response to sceptics mirrors that of Raoult, blaming an enemy that seeks to silence them: in Didier's case, the pharmaceutical industry and its financial interests (Berrod, 2020), and for Rajoelina, anti-African sentiment rooted in colonial attitudes. These defences can be difficult to refute because the purported enemies really do exist and may very well exert malignant influences, but not necessarily in the specific cases at issue. How, then, to discern legitimate concerns from attempts at obfuscation?

In the case of COVID-Organics, the fact that the remedy was promoted by a politician, with little if any direct communication from the scientists who supposedly developed and tested the remedy, as well as the dissent by Madagascar's own academy of medicine are certainly cause for suspicion. It also exemplifies the relative lack of voice and power of African scientists, in which Rajoelina is complicit. What would have occurred if Malagasy scientists had been given a platform to comment on Covid-Organics on the same media outlets that Rajoelina used? Furthermore, I submit that in evaluating Rajoelina's claim that he was being ridiculed due to colonial attitudes, it is important to recognise that colonial attitudes may indeed contribute to at least some of the backlash that he experienced and/or the manner in which the episode was presented and interpreted in media and popular opinion, all the while interrogating whether the actions that he is defending are decolonial. If, as I have argued, Rajoelina's actions were in fact anti-African and effectively reinforced a form of endogenised coloniality shrouded in the sheep's clothing of pan-Africanist language, the accusations of colonialism that he levied as defence against his critics can only be considered invalid. Finally, we must affirm legitimate critiques and demands aimed at colonial matrices of power operating at sub-national and intersubjective scales. The co-optation of decolonial and pan-Africanist language as a cover for bad acts is inherently exploitative, a characteristic that it shares with coloniality and that we must indict as such.

Conclusions: Whither from here?

If crises are revealing of true character, the COVID-19 pandemic has certainly engendered a moment of truth. We have witnessed feats of ingenuity and courage, as well as shocking governmental incompetence and political exploitation of the health crisis. This essay hones in on two specific sets of events amidst a very tumultuous period as instructive case studies of the ways in

which colonial attitudes continue to permeate our societies, and more specifically the broad-ranging enterprise that has come to be termed 'global health'. These events may seem idiosyncratic, but in fact they generate broadly applicable lessons. Locht and Mira's comments illustrate how the forces of exploitation, marginalisation, pathologisation, and saviourism persist in what one could describe as the academic-medical empire. Rajoelina's promotion of Covid-Organics demonstrates how the power structures of the colonial era have been transmitted beyond the temporal bounds of colonisation, and how the elites who perpetuate these colonial matrices of power cynically exploit anti-colonial rhetoric to excuse their misdeeds.

In his work exploring the manifestations of coloniality in scientific inquiry in Africa, the philosopher Paulin Hountondji (2013, pp. 198–227) laments the continued dependence on external funding and institutions, the primacy of exchanges (sometimes highly asymmetric) along a Global North/South axis over South-South collaborations, and the promotion of scientific questions appealing to a Western audience, with a concomitant intellectual marginalisation of African initiatives. He advocates for a process of 'reappropriation', of dismantling of the subaltern relationship between the periphery (consisting of nations and people who were formerly colonised or currently in the grips of neo-colonialism) and the seats of power located in the metropolitan centres of the (neo)-colonial powers. Part of this process involves the revalorisation of indigenous or traditional knowledge, and the development of evaluation methods to confirm or refute these ideas, which of course requires investment in local infrastructure and human resources. I would add to Hontoundji's prescription a call to centre equity in efforts to confront coloniality.

At its core, decoloniality seeks to interrogate rather than entrench power, and to abrogate structures that perpetuate exploitation and dispossession. As such, equity must be a guiding principle in the application of decolonial practice in global health. Such an approach should aim to dismantle structural vulnerability of both individual citizens and nations. We must be wary of and denounce those who advance or profit from such structural vulnerabilities yet wield accusations of coloniality as a shield against legitimate critiques and demands. With equity in mind, the nations of the Global South can invest in health systems that address the needs of the most vulnerable and diminish reliance on external systems, thus rendering them more resilient. Such systems can integrate local knowledge and value systems to benefit the health of the public. With equity in mind, those in the developed world who seek to practice medicine or conduct research in poorer nations will be driven to examine their own motives, recognise power dynamics, and empower the intended beneficiaries of their efforts, while in the long term supporting the independence of local initiatives. I am heartened to see ever increasing calls to, at long last, decolonise global health (Büyüm et al., 2020; Pai, 2020). I am hopeful that, in spite of the terrible toll it has inflicted, this crisis will also serve as an opportunity to establish more equitable partnerships and invest in local infrastructure and human resources to respond to this pandemic and the ones yet to come.

Acknowledgements

I would like to express my deep gratitude to Idriss Fofana, JD, and Amir Mohareb, MD, for their help in refining the ideas presented in this work and for their insightful critiques and edits.

Disclosure statement

The author holds stock ownership in the pharmaceutical company GlaxoSmithKline.

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