# African Economies, Societies and Natures in a Time of COVID-19

**By Reginald Cline-Cole**

Several correspondents of mine have suggested that it makes a nice and welcome change that something this big, this bad, this scary and this seemingly predictable is not coming out of Africa. 'This' and 'it' being, of course, the all-encompassing and still evolving phenomenon of Covid-19 or coronavirus, which ROAPE has been covering in the journal and online. And with good reason for, as others have already observed, the time of coronavirus is not just leaving an indelible mark on the year 2020 but might well be transforming neoliberal capitalism in previously unimaginable ways. The virus continues its inexorable advance  and, having taken some time to reach Africa from Europe and Asia, has spread rapidly since its reported arrival in mid-February, with confirmed cases numbering some 4300 people spread across  (African Arguments 2020), and more than 9000 people in  (ACSS 2020). As elsewhere, increasing infection numbers (and, sometimes, rates), imploding economies and disrupted social interactions have fuelled mutually reinforcing health and economic crises, precipitating sometimes.

And this despite, or sometimes because of, high-level policy and other discussions about, and adoption of, frequently exceptional measures which aim to slow the transmission and spread of the virus and prevent the worsening of what is already considered by many as a global crisis of unprecedented threat, impact and uncertainty In the process, as Bird and Ironstone note, '[p]ower structures are being radically re-arranged in our societ[ies] right now and if we lose our capacity to

criticize the future may be beset by new, even more damning ones.'

It is thus vital that Theophanidis clarifies that his call for 'distancing' aims to create space for critical thinking and careful reflection, notably in a context in which digital, mostly social, media connectivity is helping to counter the isolation of 'physical social distancing'. As numerous and varied examples of radical digital activism and solidarity which have emerged demonstrate, it would be regrettable if far-reaching lessons were not learned from crises precipitated by the pandemic and the varied responses to them.

**Does Covid-19 discriminate?**

Available data on age–sex distribution of confirmed cases for the WHO African Region indicate that, overall, older men would appear to be disproportionately affected by Covid-19 with a preponderance of males (1.7:1 male-to-female infection ratio) across all age groups and a median age of 36 years (range of 0–105). Further instances of disproportionate impact based on religion, class, occupation or ethnicity will no doubt emerge in time, notably as readily available details on the demographics of coronavirus victims extend beyond the fundamentals of age, sex, nationality, residence and travel history. In the UK and USA, of course, such metrics have been invaluable in identifying the overrepresentation of Black, Asian and Minority Ethnic (BAME) health and care workers and volunteers among coronavirus fatalities. Similar racial and ethnic disparities characterise wider BAME community and hospital in-patient infection and death data from coronavirus, with black people (four times), Bangladeshi and Pakistani (three and a half times) and Indians (two and a half times) more likely to succumb to Covid-19 than white people in England and Wales. The phenomenon has attracted extensive media and other coverage which has focused on health inequalities and risk factors, deprivation, affluence and racial discrimination, and in the absence of acceptable causal explanations for the overrepresentation.

But it has been left to organised labour and popular mobilisation to extract hard-won concessions from state actors and the public–private healthcare complex to institute an official enquiry, provide adequate supplies of personal protective equipment (PPE) for frontline health, care and allied workers and expand coronavirus testing opportunities for these workers and their families (NHS Confederation 2020). Special compensation programmes for families of NHS staff (and, in England, social care workers) who die from coronavirus have also been announced, although the level of compensation is considered inadequate by some, and labour unions, among others, have called for the scheme to be extended to cover all key workers who die from the disease.

And yet, as tardy, reluctant, inadequate and reactive as these state interventions have undoubtedly been, it is social mobilisations which have 'forced the state to take on its responsibilities'. These have included medical professionals and cross-party campaign MPs 'breaking silence' over Covid-19's disproportionate impact on particular sections of society, which itself speaks to the promise of social action and emancipatory politics in influencing (post-) Covid-19 politics and realities.

But as the coronavirus BAME casualties and fatalities include Africans and people of African descent whose remittances are often integral to the livelihoods and survival strategies of family at home, their existential struggles have not been lost on Africans at home and in the diaspora. Indeed, as social media exchanges were quick to indicate, for countries like Sierra Leone and Zimbabwe, among others, the earliest known coronavirus deaths were of their (often dual) nationals in the diaspora rather than at home, where the continent's first fatality was a German tourist in Egypt. For many, family, friends, colleagues and casual acquaintances would eventually succumb to the virus, in my case across three continents.

THE ELEPHANT

Thus one of my acquaintances regretted what he saw as a ‘lamentable waste’ of African medical and health expertise which was going to be both sorely needed and badly missed on the continent, if the worst predictions of Covid-19 were ever realised. A second drew a comparison between these coronavirus deaths and the often tragic demise of undocumented migrants along trans-Saharan and Mediterranean routes to Europe, suggesting that both groups had paid the ultimate price in their respective attempts to escape the poverty of opportunity in Africa.

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Meanwhile, in Zimbabwe, frontline medical staff followed up on a protest strike which had been observed jointly by the Hospital Doctors Association (ZHDA) and Professional Nurses Union (ZPNU) in mid-March to highlight the shortage of PPE for health workers in the country’s hospitals. The Zimbabwe Association of Doctors for Human Rights (ZADHR) sued the government in the High Court in early April to compel it to provide adequate equipment and supplies to enable frontline medical practitioners and healthcare workers to tackle the Covid-19 crisis safely and professionally and, in the process, to significantly improve public access to functioning quarantine and isolation facilities.

Similar protests have been widespread across the continent, many representing a continuation of long-running dissatisfaction with public health provision predating coronavirus. In one of the more recent of these, coronavirus frontline workers in Sierra Leone who announced they were going on strike in early June were joined at the start of July by doctors refusing to treat coronavirus patients in quarantine or isolation facilities in protesting government failure to pay outstanding bonuses, ‘hazard pay’, promised as incentive to persuade health workers to agree to treat Covid-19 patients during the outbreak, often with inadequate PPE, diagnostic and therapeutic equipment and supplies.

Thus, a government with the foresight and presence of mind to draw up a Covid-19 response plan before the outbreak of the pandemic, and probably earlier than anybody else on the continent, stands accused of not only reneging on the memorandum of understanding (MOU) signed in April with the Sierra Leone Medical and Dental Association (SLMDA) to facilitate this Covid-19 response, but also of failing to renew the MOU before it lapsed three months later (Inveen 2020a). Recalling that disasters like pandemics are influenced by human ‘decisions, attitudes, values, behaviour, and activities’ one cannot but wonder whether there is indeed merit to the SLMDA’s claim that the government does not appear to be particularly interested in resolving the dispute, and if so what the political reasoning behind such a choice might be.

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Clearly, the ZHDA/ZPNU, SLMDA and NHS struggles share more than just a generic similarity. There are recognisably Zimbabwean and Sierra Leonean names on published lists of NHS and care worker coronavirus fatalities. And in all three cases, albeit in noticeably different ways, the struggle to pressure the state to assume its responsibility in relation to public health and wellbeing is rooted in austerity, long predates Covid-19 and is fuelled by perceptions of official inefficiency, neglect and corruption. In addition, as recent SARS and Ebola epidemics have shown, potential risks and opportunities for corruption are significantly increased during major health crises, most commonly

in drug and equipment procurement, leading to calls for increased oversight, accountability and transparency during the coronavirus pandemic

Thus, a major grievance of the SLMDA, for example, is a perceived ‘misuse of funds for the coronavirus response’, a reaction to official procurement priorities which have seen 20% of Sierra Leone’s total coronavirus budget being spent on new SUVs and motorbikes, with only a tenth as much on medical equipment or drugs, leaving PPE in constant short supply and contact tracers seemingly unaffordable. The national Coronavirus Response Team, for its part, justifies the delay in disbursing promised bonuses by citing the necessity to both establish the identity of frontline health workers and ensure that hazard pay went only to those entitled to receive it But as improperly disbursed hazard pay was one of several examples of mismanagement of funds by public officials during the Ebola crisis with its high health worker mortality rates SLMDA impatience and suspicion do not appear entirely unfounded. And, at nearly 11%, Sierra Leone’s ratio of health worker infection to total reported infections is among the highest on the continent.

Meanwhile, Zimbabwean health professionals have also embarked on the latest in a series of strikes, partly to protest at the erosion of local purchasing power and living standards by hyperinflation and demand payment of their salaries in US dollars, but also to highlight both police harassment of striking nurses and the perennial shortage of PPE at a time of rising incidence of Covid-19.

But whereas SLMDA appear to be contending with seemingly misplaced procurement priorities, their Zimbabwean counterparts are confronted with alleged criminality, which has seen the sacking of the country’s minister of health, who has also been charged with corruption and abuse of office for the illegal award of a large contract (since revoked by government) for PPE, testing kits and drugs to a company which would deliver these supplies at hugely inflated cost.

The combination of a worsening economic crisis and sharply increasing coronavirus infection totals (including of health workers) has seen opposition politicians make common cause with the media and popular forces to decry corruption and demand greater accountability, while calling for a national day of protest against ‘corruption and political challenges’ at the end of July.

The authorities refused permission for the 31 July protests to take place, on the grounds that it would be subversive, unconstitutional and anti-democratic (BBC 2020d), as well as violating Covid-19 pandemic regulations at a time when there has been a spike in coronavirus infections. As a result, they claimed, a dusk-to-dawn curfew and tighter restrictions on movement had to be imposed.

It is presumably also in the common good that leading organisers/supporters of the proposed protest have been arrested, charged to court and refused bail.The example of state officials rewriting coronavirus reality to suit a favoured narrative is a recurrent and intensely political one, to which we return later.

**Philanthro-capitalism in coronavirus times**

An earlier prolonged doctors’ strike over pay and conditions in Zimbabwe had been called off only in January this year, when the ZHDA accepted an offer of funding for a fellowship programme for its members which would guarantee a monthly subsistence allowance of up to three times their salary for a period of six months from Strive Masiyiwa, the country’s wealthiest individual.

Following the PPE protests in March, funding to cover the cost of PPE for doctors and other health workers was added to the original offer, which was also extended to all nurses, as well as doctors in non-state hospitals, and expanded to include health and life insurance cover with cash or lump-sum benefit in the event of ‘hospitali[sation], … permanent disability or death from the virus’. Although

he is Zimbabwean born, Strive Masiyiwa presides over his Econet Group from London, where he currently lives and from where he has undoubtedly been monitoring the wide variety of local responses to the pandemic worldwide, or at least in those world regions in which Econet has a presence.

But while nothing in the way of private donations to Sierra Leone's coronavirus response effort is likely to have come anywhere near the sums certain to have been involved above, reports from Nigeria indicate that Masiyiwa's fellow billionaires have also been making substantial donations to the (federal) Nigerian Private Sector Coalition Against COVID-19 (CACOVID) and their state equivalents, as have corporate entities (often fronted by the same individuals). Is it likely, then, that we might have a case of transnational capital ostensibly contesting state in/action as part of a wider coalition while still acting in its own long-term interest?

Masiyiwa's conglomerate Econet, for example, combines telecom, mobile phone, fintech and power distribution enterprises which operate across large parts of Africa, but also in the Americas, Asia Pacific, Middle East and Europe. The funding/fellowship programme for health workers is to be established and run by the Higherlife philanthropic family foundation, while Ecosure, the insurance arm of one of the Econet Group companies, will underwrite the insurance component of the offer.

Similarly, Nigerian media reporting of the private coronavirus response donations by individuals and corporate entities gives as much prominence to the identities of donors and their net worth as to the size/purpose of their donations and sources of wealth, thereby fulfilling invaluable public relations and/or corporate social responsibility (CSR) functions, as well as playing a commercial advertising role. Consequently, while donor state of origin or residence tends to be the primary beneficiary of private philanthropy, corporate donations often favour populations and institutions in states and regions of direct commercial importance. Thus Aliko Dangote, Africa's richest individual, has provided a fully-equipped and staffed Covid-19 testing facility, as well as part-funding a wide range of vital public interventions in coronavirus prevention and containment via private and corporate donations in his home state of Kano (and, to a lesser extent, Lagos State, where the Dangote Industries group has its head office).

He also assumed shared national leadership of CACOVID's quest to raise funds from private and corporate sources for federal and state Covid-19 response; and, by making the largest corporate donation to the fund to date via the Aliko Dangote Foundation (ADF), triggered something of a 'giving war' of donations and pledges among his fellow billionaire donors. He also made a further multi-million-dollar donation to the Nigeria UN COVID-19 Basket Fund which aims to provide support to individuals and households trying to rebuild livelihoods disrupted and/or undermined by the coronavirus pandemic.

In the end he and his fellow donors are publicly thanked by President Muhammadu Buhari (who encourages other high-net-worth individuals – HNWIs – to follow their example). Dangote is also thanked by the governor of Kano State for his services to coronavirus prevention and response, with which his name becomes inextricably linked in media reports, which almost invariably also mention his equally sterling contributions during the earlier Ebola epidemic. Like Strive Masiyiwa, with whom he earlier collaborated on regional and continent-wide Ebola response efforts, then, this enhances his reputation as one of Africa's biggest philanthropists and, as CEO of 'Nigeria's most profitable company' (Augie 2020), one of the continent's most successful business people. Is this what capitalist philanthropy in a time of coronavirus looks like? And is it as accommodating in its business practices as it is in its public giving?

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partly to protest at the erosion of local purchasing power and living standards by hyperinflation and demand payment of their salaries in US dollars, but also to highlight both police harassment of striking nurses and the perennial shortage of PPE at a time of rising incidence of Covid-19.

While philanthropy is not restricted to wealthy individuals and profitable corporations, their role can be strategic and decisive. UBS and TrustAfrica (2014), in a jointly published study, document and seek to analyse how and why this is the case for African philanthropists/philanthropy during 'normal' times. But as the Dangote and Masiyiwa examples and numerous others like them illustrate, this is also largely the case during the ongoing Covid-19 pandemic, with its varied, changing and often expanding demands/appeals and frequently inadequate – if improving – philanthropic responses (Julien 2020). Experience with previous epidemics and pandemics, supplemented by emerging insights from Covid-19, have informed the design and implementation of emergency coronavirus plans and strategies worldwide, including for dealing with voluntarism and managing donations (Alexander 2020). In emergency coronavirus planning scenarios, responsibility for external donations and government/state resource commitments is routinely combined with administrative oversight for internal donations of various kinds.

In practice, this creates a pressing, possibly overwhelming, need to coordinate appeals for assistance while managing a diversity of resources earmarked for coronavirus response in an accountable and transparent way (Transparency International 2020). Notably, the circumstances surrounding the previously mentioned sacking of Zimbabwe's minister of health, and ongoing legal and media challenges to UK government officials against the lack of transparent and competitive tendering in the award of Covid-19 related contracts (Monbiot 2020) remind us that expectations of resource governance, transparency and accountability are not just ethical and moral, but frequently political and legal too.

And that, like the good governance agenda as a whole, these expectations can be heavily neoliberal in tone and intent, and as process. Significantly, however, expectations of transparency and accountability in how donations are managed or used have not historically been routinely extended to how the wealth which makes corporate and HNWI Covid-19 philanthropy possible is generated in the first place. How best to explain such imbalances in what has been described as the power of process and practice in philanthropy (Mahomed and Moyo 2013)? And how best to prevent its use in, say, 'offset[ing] reputational damage or exploitative practice' (Mahomed 2014)?

The point is that African philanthropy is increasingly seen as indispensable to the emergence of a self-reliant continent, with corporate philanthropists looking to strengthen links between business and philanthropy, considering 'investments with a social impact' a suitable means for achieving this. Aliko Dangote Foundation and Higherlife Foundation, for example, thus function as CSR units of Dangote Industries Ltd and Econet, respectively. Their donations or pledges in both cash and kind undoubtedly give a significant boost to the overall coronavirus response effort, to include staff recruitment, training and remuneration. Equally, and particularly noticeably, they also impact directly on local and import markets in specialised medical equipment and supplies, as well as in two- and four-wheeled motor vehicles, among other commodities. Yet, these markets might well be dominated by manufacturers and/or intermediary suppliers which are subsidiaries of corporate partner organisations to the charity foundations through which philanthropy is dispensed by conglomerates in the first place.

More directly, how have corporate philanthropists reacted to the disruptive effects of Covid-19 and the varied responses to it on the factory floor, behind the bank counter, at the plantation gate and in front of the computer screen? Specifically, were business practices adequately adjusted to reflect

the new normal in a time of coronavirus? Did they readily and effectively incorporate workplace Covid-19 preparedness planning and response strategies, including testing facilities where appropriate? Were adequate supplies of PPE, relevant equipment, water, soap, sanitisers, etc. made available to employees? And where, as with several of the corporate donors in question, their businesses operate across national boundaries, were common standards maintained across the board or did arrangements differ between 'home' and 'foreign' sites and workforces (and, if so, why and with what consequences for workers)? Overall, do philanthro-capitalists lead by example here in a way reminiscent of their public giving and pledging? As Mahomed (2014) notes, 'the ethics of how philanthropy money is made (especially if made in an endeavour that disadvantages those it now seeks to support) must be called into question.' That we are in the middle of a pandemic is no reason not to at least raise the question of the often differentiated nature of the process by which donated wealth is made or, indeed, of how coronavirus has been (or is likely to be) exploited for capitalist investment and profit accumulation.

But the lesson of Covid-19 need not involve either depoliticising philanthropy (it has after all contributed actively to the long-term process of privatising and commercialising formerly public health systems on the continent) or underestimating the complex dynamics of emergent solidarity between often conflicting and competing class interests. Take the following two parallel and competing but interrelated phenomena. On the one hand we had Donald Trump's largely futile attempts to encourage wider use of the labels 'Wuhan Virus' and 'Chinese Virus'; his still unfounded but periodically repeated claim that SARS-CoV-2 was developed in a Wuhan laboratory; his insistence that the WHO is so severely compromised by links to China that its handling of the pandemic was tardy, grossly inadequate and ineffective, as well as lacking transparency; and his threat to withhold American funding for the organisation – a political stance which has not won widespread or unqualified support from other major WHO donors who have publicly supported the agency and its director-general, if not necessarily China's reported handling of the initial stages of the virus outbreak.

On the other hand, there are official Chinese state objections, denials and counter-accusations; and the skilful 'weaponisation' of the material and symbolic significance of its carefully cultivated (self-)image of generosity to, and solidarity with the world's needy and oppressed, particularly in coronavirus times. So, alongside Chinese government support in cash, kind and personnel provided to selected African and other countries under threat from coronavirus, we also have worldwide donations of medical equipment and supplies in support of Covid-19 response efforts by private philanthropic foundations linked to Jack Ma, China's wealthiest man, and member of the Chinese Communist Party.

Ma's corporate philanthropy has extended to donations to New York authorities and the WHO in the wake of Trump's de-funding threat, as well as to all of Africa, and has included an online training manual for clinical treatment of coronavirus based on first-hand experience of doctors in Zhejiang and the Global MediXchange for Combating Covid-19 programme with its International Medical Expert Communication Platform. But while Jack Ma's donations have been widely celebrated in Africa as promptly and efficiently delivered, Chinese government donations have not been universally welcome, partly because of reported poor quality and questionable reliability of donated supplies and equipment.

Ma's philanthropy has made him as newsworthy at home and abroad as President Xi Jinping and the Chinese Communist Party leadership, who see Chinese state and private Covid-19 philanthropy as part of a wider coronavirus diplomatic strategy designed to distract attention from Chinese state contribution to the initial 'escape' or spread of the virus, while positioning their country as champion of the fight against the pandemic. This assumes heightened significance in places like Europe and Africa where, in contrast to Jack Ma and his private foundations, the Chinese state has suffered

Covid-19-related reputational damage. Indeed, the arrival of Nigeria's allocation from Jack Ma's Covid-19 donation to African countries via the African Union's Centres for Disease Control and Prevention was a major prompt to local media and popular commentators to challenge local HNWIs to emulate Ma's philanthropy. In contrast, the Nigerian Medical Association, Trade Union Congress and main opposition party strongly opposed federal government approval for a team of Chinese medical professionals funded by the state-owned China Civil Engineering Construction Corporation to provide direct support for the government's Covid-19 response efforts, citing rumours of an upsurge in coronavirus infection and mortality in other countries following the arrival of Chinese medical personnel.

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There was also residual popular resentment at the widely reported scapegoating of African migrants in China at the outbreak of the pandemic which had drawn official protests from the Nigerian and other African governments. But as the donation which also included a consignment of medical equipment and supplies had been announced as a fait accompli, government officials and spokespersons would spend media appearances trying to justify the decision, pacify local doctors, rebut opposition claims and win public support through a fascinating mix of obfuscation, mendacity, petulance, deflection and insinuation in a desperate attempt to deliberately downplay Chinese state involvement and thus avoid a diplomatic incident. So in their different ways, and like the Zimbabwe government's desperate bid to silence internal dissent and protest which we encountered earlier, Trump's assault on WHO handling of the pandemic, official Chinese and Nigerian government public relations and propaganda assaults on their respective (and wider) publics indicate active involvement in what Carrie Gracie has described, with specific reference to the Chinese ruling class, as rewriting Covid-19 facts to suit their narrative.

**Politics must not be allowed to stand**

The world is still in the grip of a coronavirus pandemic; that Africa might or might not be its current epicentre; and that nobody knows for sure how Africa's many 'other' or local epidemics will evolve over the next few weeks, months or even years. Yet this has not stopped multilateral institutions and multinational corporations from outlining a variety of options for exiting lockdowns and, ultimately, the entire or whole pandemic; or indeed predicting and modelling the contours of post-coronavirus 'new normal' continental and/or global economies. As an increasing number of countries exit lockdowns (and enter new ones), this should awaken an urgent desire among progressive forces to redirect the focus of attention to a determined pursuit of an analytically rigorous understanding of the differentiated spread and impact of, and state and other responses to Covid-19 – and in so doing to return also to what ought to be our core concern: the political economy of uneven incorporation of African economies, societies and natures into the world economy, the accompanying implications for social, spatial, structural and other forms of differentiation, and the latter's manifestation within and between population, place and space/territory. For, as Philip Alston reminds us, '[t]he coronavirus has merely lifted the lid off the pre-existing pandemic of poverty. Covid-19 arrived in a world where poverty, extreme inequality and disregard for human life are thriving, and in which legal and economic policies are designed to create and sustain wealth for the powerful, but not end poverty. This is the political choice that has been made.' It is a political choice that cannot and must not be allowed to stand unchallenged either in the current coronavirus times or in a post-Covid-19 world.

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