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Godwin Etta Odok

Federal University Wukari

ABSTRACT

Infectious diseases such as smallpox, tuberculosis and leprosy have all invaded rural Nigeria at periods when colonial hegemons assume supremacy over indigenous knowledge systems. The most recent infectious disease, Coronavirus Disease 2019 (COVID-19), spread within an interconnected world in manners that exposed the false assumption that the global North has all the expertise and solutions to salvage devastating health, economic and social impacts of infectious diseases. Adopting a historical research approach which engaged archival records and intergenerational dialogues in Esham, Ekporinya (Ekajuk Kingdom); Egbe, Ndum (Mbube); Bansan-Osokom, Borum, Okundi, Katchuan (Boki); Ishibori (Ogoja); this article argues that responses to infectious diseases' emergencies in rural Nigeria are firmly enmesh in forms of belittlement and exclusion of the narrative autonomy of the people to handle infectious diseases' emergencies. Findings coalesce to indicate that the 'capacity approach' in handling infectious diseases' emergencies in rural Nigeria is characterized by discernible secrecy; it is non-curative, urban-based and aims at serving the medical needs of 'very important personalities' (VIPs), their immediate dependents and servants.

Keywords: infection diseases, public health, coloniality, covid-19, indigenous knowledge.

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Keywords: infection diseases, public health, coloniality, covid-19, indigenous knowledge.

Author: Department of Sociology Federal University Wukari, Taraba State, Nigeria.

I. INTRODUCTION

The medical history of infectious diseases in rural Nigeria is not too different from that of other regions of the African continent. Though colonized and pillaged for over three hundred years, Africa traditions and cultures have displayed vibrancy in accentuating that illnesses, including illnesses caused by infectious diseases, are not derived from chance occurrences, but through spiritual imbalances and social inequalities (Olaniyi & Moletsane-Kekae, 2018). This position no doubt differs sharply from modern scientific medicine of the global North. It is widely acknowledged that African societies were better established and more populous than societies in the Americas and Europe before the colonization of the African continent (Ndlovu-Gatsheni, 2018). African tribes in present day southern Nigeria, such as Nkum, Yala, Boki, Mbube, Yakoro, Yachi, Akaju, Aferike, had been in contact with the Europeans since the early part of the nineteenth-century where they established mutual trade relations with Europeans in oil palm products (Attoe, 1990). Manton (2011) noted that the structure of the

nineteenth-century interactions between Africans and Europeans was largely trade-based. During this period, rich urban life evolved in Africa with major kingdoms and empires created with socially complex towns and cities (Bulhan, 2015; Manton, 2011; Ndlovu-Gatsheni, 2018; Baronqy, 2008). As a result of the increased interaction of African tribes with the Europeans, the production and export of palm products, palm oil and palm kernel, became the mainstay of the nineteenth-century legitimate trade in most African kingdoms and empires, especially kingdoms and empires in southern Nigeria with profit-making as a cardinal priority for the Europeans (Attoe, 1990; Heidegger, 2008). Even though oil palm products had been used locally for a number of centuries, the market-oriented oil palm trade overturned the earlier system of local trade where 'common wellbeing' of community members and 'not profit-making' was the motivation for trade (Attoe, 1990; Galbraith & Klaus, 2019; Granovetter, 1985; Heidegger, 2008). Identified trade routes for the oil palm trade were: Obudu-Ogoja-Bansara route; Itakum-Akaju-Bansara route; and, the Ikerri-Ezekew-Bansara route (Attoe, 1990).

Special traditional methods were developed for its collection, preparation and processing. Small-scale village producers continued with these traditional methods until the early part of the twentieth century when oil palm products became basic exchange goods for imported manufactured products at local markets (Attoe, 1990). Modern devices for oil palm production were introduced around the 1940s at strategic locations within southern Nigeria to serve as export terminals for European firms, where oil palm products were collected, tested, purified and prepared for shipping overseas (Attoe, 1990). These modern devices for oil palm production were located in places such as Egbe-Mbube, Okundi, Katchuan-Irruan, Borum, Bansan-Osokom, and Bansara (National Commission for Museums and Monuments, 1986). Around this same period, Nigeria's palm oil and kernel export accounted for about 50-70% at the world market (Attoe, 1990), and there were also accounts of widespread incidences of infectious diseases, particularly smallpox, tuberculosis, and leprosy within southern Nigeria.

This article reflects on how Global-North inspired (colonial) hegemons have always assumed supremacy over indigenous knowledge systems in the handling of infectious diseases' emergencies in rural Nigeria. Specifically, the article interrogates tensions between capacity and autonomy as relating the handling of infectious diseases emergencies, including the Coronavirus Disease 2019 (COVID-19) pandemic in rural Nigeria. The article argues that capacity building for community health workers to facilitate community-led solutions to infectious diseases' emergencies, particularly COVID-19, spearheads western colonial hegemonies intended to only fill externally predefined lack in capacity within rural Nigeria. This thinking is predicated on a decolonial interpretation of infectious diseases' emergencies which involves the asymmetrical and pyramidal constitution of global politics and the world order. The article critiques the assumption that there is a singular system of modern knowledge which pervades the mental universe and supposedly provides answers for every human problem across the globe (Ndlovu-Gatsheni, 2020). In the context of this article, decolonial thinking believes that Eurocentric conceptions of humanity are rooted in racist and sexist social classifications, racial hierarchization and capitalist approaches of medical care. Findings of this article have implications for public health research in terms of explicating the complex interrelationships between socio-political factors that affect health and wellbeing in rural Nigeria.

The paper is divided into three major parts. The first part discusses the methodological design through which evidence for the article emerged. The historical research approach consisting of archival records and intergenerational dialogues was employed for data collection in Esham, Epkorinya (Ekajuk Kingdom); Egbe, Ndum (Mbube); Bansan-Osokom, Borum, Okundi, Katchuan (Boki); Ishibori (Ogoja) communities. The second part of the article discusses empirical evidences relating to the handling of infectious disease's emergencies in rural Nigeria where

participants showed self-awareness in decoding the interconnectedness of the world in the era of global capitalism. They distinctively showed that infectious disease' emergencies unpack the essential character of European imperialism and colonization project which focuses at willfully destroying the autonomy of the rural people to solve their health emergencies, including emergencies relating to infectious diseases. The concluding part of the article reiterates that interventions for responding to infectious diseases' emergencies in rural Nigeria are framed from the perspective of colonial medicine. Consequently, this distorts and erases narratives of the capacity and autonomy of the rural people to effectively respond to their health emergencies.

II. METHODOLOGICAL NOTE

The methodological design for the study wherein evidence for this article emerged was the historical research design which engaged archival records from the Ogoja Local Government Council collections, and intergenerational dialogues involving traditional heads and clan heads (80 persons); men group (80 persons); women group (80 persons); youth group (80 persons); and combination of all groups (80 persons) in Esham, Epkorinya (Ekajuk Kingdom); Egbe, Ndum (Mbube); Bansan-Osokom, Borum, Okundi, Katchuan (Boki); Ishibori (Ogoja). This research design enabled a simultaneous exploration of medical practices as being culture-bound and historically contingent social forms while also analyzing coloniality as an instrument of Western conquest and continual domination (Beck, 1999). The research design also involves the review of literature that interrogated tensions between capacity and autonomy as relating the handling of infectious diseases emergencies, including the COVID-19 pandemic in rural Nigeria. Articles published in PubMed, Google Scholar, MEDLINE and Web of Science database searches were reviewed. These included data from regional and international organizations that addressed infectious diseases emergencies, including the COVID-19. Specifically, data from: Council for the Development of Social Science Research in Africa (CODESRIA); African Union COVID-19 Response Fund; the Center for Disease Dynamics, Economics & Policy (CDDEP); the International Society for Infectious Diseases (ISID); and World Health Organization (WHO) were reviewed. No date restrictions were imposed on the retrieved data or information from these organizations, and all types of research studies, including systematic reviews, cohort studies, case-control studies, case series, case reports, randomized controlled studies, and cross-sectional studies were explored. This was explored in order to ensure the qualitative element of diversified methods. It was essential to explore all sources of information in order to generate the best understanding of infectious diseases emergencies within rural contexts. Searches were confined to articles written in English and published in a peer-reviewed or organizational journal in order to retain the integrity of the informational source. Data was content analyzed using the circular hermeneutic process described by Ricoeur (Baronqy, 2008). This allowed for an interpretation to emanate from a series of analytic steps and it recognized the relationship between the interpreter and the interpretation.

2.1 Coloniality of Response to Infectious Diseases' Emergencies in Rural Nigeria

Apart from the latest COVID-19 disease, no evidence accounted with certainty on when, where, and how other infectious diseases appeared in rural Nigeria. However, findings suggest that the reason why it proved difficult to trace the origins of other infectious diseases in rural Nigeria is because until colonialism, there was a lack of a standardized medical lexicon for these diseases among tribes that made up rural Nigeria. Koplow (2003) provided a clue that some of the best evidence about the origins of infectious diseases epidemics come from war records. He argued that in about 1350 B.C, there was an account where the Hittite armies were devastated by a fatal infectious disease that apparently originated among the Egyptian prisoners of war who were captured in Syria. This disease killed the Hittite king, Suppiluliumas I, as well as his son and successor, Arnuwandas II, and led to a period of degenerative instability within the

Hittite empire. Similarly, smallpox he also argued killed about one-quarter of Athens's soldiers and countless civilians around 430 B.C undermining that city-state in its competition with Sparta. Koplow (2003) further accounts that Alexander the Great's foot soldiers, while invading India in 327 B.C, suffered from a fatal infectious disease believed to be smallpox.

The study findings recognized that outbreaks of infectious diseases do occur in an irregular geographic pattern. Within rural Nigeria, it was described that the transmission patterns of infectious diseases follow this shape: first, the diseases spread through relatively close contacts where the disease is either propelled through the air for short distances or passed along by immediate physical contact with a diseased person or with his or her clothing. Proximity is required for dispersion of infectious diseases. Second, they do appear in an acute, manifest form, these cannot be carried secretly or without visible symptoms. Third, infectious diseases never struck the same person twice. This means that anyone who contracted the diseases and manages to survive them incurs lifelong immunity. Fourth, infectious diseases affect humans exclusively and not any other organism.

As regard the autonomy of rural Nigeria in handling infectious diseases, especially the COVID-19 pandemic, participants showed self-awareness in decoding the interconnec tedness of the world in this era of global capitalism. Their assertion affirms that they already know enough. Participants recognized that COVID-19 additionally unpacks the essential character of European imperialism and colonization project. They argue that at the core of capacity building for handling health emergencies in rural Nigeria is the willful destruction of the autonomy of the rural people to solve their health emergencies, including emergencies relating to infectious diseases. Externally funded capacity building according to them, begins with the notion that the rural people lack capacity to handle health emergencies themselves. This notion fails to see and build on already-existing autonomies among the rural people. Participants aver that capacity building for handling health emergencies entails the production of subjects without addressing root causes that elevate the vulnerability of the rural people to exploitations during health emergencies.

There were references to the grant of US$27.33 million approved by African Development Bank (AfDB) to the African Centres for Disease Control and Prevention (Africa CDC). Although the grant was awarded under three key components; technical assistance and capacity building alone which goes back to foreign 'experts' or 'partners' in the global North took US$19.33 million, while institutional support and contribution to the African Union COVID-19 Response Fund took just US$7 million and US$1 million respectively. Thus, the coloniality of health emergencies in rural Nigeria was seen to manifest in negligence, acquiescence and utter disregards for the fatal implications of global inequality; that is, a consistent preference for orthodox or western capacity and medicines against local or indigenous capacity and medicine. Participants note clearly that it is not the health emergencies that are political, but it is the global systems that govern these health emergencies that are political. They recognized that these global systems consist of a structure of terror that is empowered by inverting life and death. Coloniality here is represented by "*... modern sovereignty which is exerted by controlling mortality as life has come to depend on the deployment of overturning life and death...*" (Excerpt from the combined Intergenerational Dialogue at Esham on 25 May 2021). This is in consonance with Mbembe's (2019) view that late modern sovereignty relies on the power to create a group of people who, unceasingly confronted by death, live at life's edge. This right to kill is what according to Mbembe (2019) keeps colonial terror, biopower and a state of siege in former colonies alive. Participants also showed that the deployment of basic techniques of territorial state power to control COVID-19 and other infectious diseases in rural Nigeria constitute coloniality. Participants insisted that the dynamics of health emergencies in rural Nigeria are of slow violence, as the power

over who gets treated or vaccinated is externally outsourced.

This insistence further falls in line with the reality that capacity building for health emergencies in rural Nigeria unfortunately holds a prominent place in grant applications, deliverables, metrics for success, and funding programmes for so many of the global health initiatives. 'Successful' global health initiatives in this light are those whose capacity building aims to promote partnership in ways that partners with established experience build knowledge or practice in communities that are less resourced. Trainings are often provided, workshop offered, and mentoring provided to build capacity. Regrettably, this capacity building has only led to one directional approach (of the expert to learner) that fails to leverage opportunities for all parties to learn from and engage each other. Santos (2014, p.19) affirms this by arguing that:

> The truth of the matter is that, after five centuries of "teaching" the world, the global North seems to have lost the capacity to learn from the experiences of the world. In other words, it looks as if colonialism has disabled the global North from learning in noncolonial terms, that is, in terms that allow for the existence of histories other than the universal history of the West.

Ndlovu-Gatsheni (2020) added to argue that the Global South had been invented and reproduced as the geography of poverty; thus, there is a reluctance to tap into the long history, experience and knowledge of Africans in tackling health emergencies and pandemics. This is probably due to the historical fact that colonialism destabilized the African people's self-confidence and agency. Thus, looking to Europe and North America for capacity building to tackle health emergencies would not help Africa at this time as there are bigger troubles in Europe and North America than in Africa. This pandemic provides an opportunity for Africa in particular and the Global South in general to showcase 'endogenous knowledge', the 'southern theory', 'theory from the South', 'epistemologies from the South' (Santos & Meneses, 2019), and 'epistemic freedom' (Ndlovu-Gatsheni, 2018) as serious initiatives which have become very important now when the rest of the world is experiencing a piece of what the African people and the Global South have been experiencing for over 500 years (Ndlovu-Gatsheni, 2020). Ndlovu-Gatsheni (2018) believes that the power and relevance of epistemologies of the Global South is that they are largely experiential and experimental knowledges.

Pailey (2017) provide examples how the Liberian people improvise protective equipment during the three-year (2014-2016) outbreak of Ebola, which killed about 11,000 people in the West African region. Improvise protective equipment have always been the basis of all inventions in tackling infectious diseases' emergencies in Africa. Ndlovu-Gatsheni (2020) showed that the Mozambican scholar, Macamo, criticized the tendency of African leaders to 'copy and paste' European responses to infectious diseases' emergencies, especially responses to the COVID-19 pandemic. He stressed that for Europe and the Global North, pandemics may be seen as extraordinary events coming to disrupt their normal lives. But for Africans and the Global South, he argued that "normality" has not been Africa's reality. He concluded that though Africa may face the same enemy as Europe and the Global North, but Africa does not have the same risk as Europe and the Global North. Leading African Intellectuals (2020) in their open letter to African leaders dated April 17, 2020, highlighted that Africa as a continent is familiar with pandemic outbreaks; thus, Africa stands in an advantaged position to effectively manage large scale crises like infectious diseases' emergencies, especially the COVID-19 pandemic. This is because Africa has a rich history and experience of dealing with and surviving epidemics and pandemics.

2.2 Colonial Relics of Health Emergencies in Rural Nigeria

The study findings confirmed earliest treatment of infectious diseases in rural Nigeria to include the designation of a god or goddess to which sacrifices were made to honour and appease the

deity when a person is infected. Tribes such as Ekajuk, Boki, Yala and Aferike have cultural practices where therapeutic bleeding to seep the body of excessive humors in order to restore the internal balance that take away the infection. 'Heat therapy' was reported to be common in Boki, Yakoro, and Ekajuk. Among the Yachi people, the 'red therapy' was reported to be common. This is a therapy where an individual infected with any infectious disease is surrounded with red-coloured blankets, curtains and the person is made to drink red liquids and use only red implements in treatments. Participants account that it was when the transmission patterns of infectious diseases became more obvious, that was when efforts at isolation and quarantine became common in rural Nigeria. Archival information confirmed the following medical items were delivered in Ogoja district during the peak of the smallpox epidemic in the area between 1940 to 1949.

Table 1: Delivered Medical Items in Ogoja District by Colonial Authorities (1940-1949)

Benefiting Communities	Individual Beneficiaries	Medical Items (Drugs)
Katchuan Irruan, Egbe-Mbube, Okundi-Osokom, Kakwagom, Obudu, Ishibori, Borum	All infected persons in the various communities	Zinci; Unguentum Hydrarg.; Oxid. Flav; Unguentum Sulphuris; Unguentum Chrysarobin; Sodii Bicarb; Acetum Ipecacuahae; Acetum Scillae; Liquor, Ammon Acct-Fort; Creta Preparata; Ammon. Carb; Carbolised oil; Infusum Gent.co.Conc; White Disinfectant; Quinine Hydrochoride; Linimentum Terebinthinae; Magnes. Sulph; Carron Oil; Zinc oxide; Creta prep.B.P; Dusting powder

Source: Intelligence Report. Ogoja Province, District of Ogoja, Sheet No. 2/1925

Participants noted that at the arrival of the British to the hinterland of Nigeria, they brought with them institutions carried over from other colonial territories. For instance, the colonial Governor-General at the centre was responsible for the execution of policies with the advice of his executive council which composed of chief officials, and could legislate only with the approval of the legislative council. Participants confirmed that the legislative council was the central and most important institution in the colonial political structure that superintended over provinces, though private hospitals that treated general illnesses were allowed to operate in remote villages. In analyzing colonial health facilities, participants drew attention to when Lord Lugard carried out his amalgamation of Nigeria's southern and northern protectorates in 1914. According to them, the introduction of native administration in southern Nigeria with the establishment of a provincial capital from which other parts of the province were administered was incongruent with local political structures. They insisted that Lord Lugard introduced *native administration* in southern Nigeria exactly in line with what was obtainable in northern Nigeria. To participants, the powers that *provincial capitals* broker made no sense to the locales, because these powers had not been possessed by them in traditional society. Thus, colonial health institutions assumed a conservative outlook as these undermined indigenous autonomy to handle health emergencies. Even when native authorities were constituted to oversee health programmes or projects, a British officer still asserted powers in the day-to-day affairs of the province, including the administration of health emergencies. Evidence prevail to confirm this same attitude in the handling of the COVID-19 emergency; even as the Seventy-fourth World Health Assembly of the World Health Organization (WHO) held on 29 May 2021 reiterates that there is need to

strengthen local production of medicines and other health technologies in order to improve access to healthcare during health emergencies. However, the underlying concern on how the local production of medicines and other health technologies in Africa will be received by the Global North in manners that foster capacity sharing, trust and accountability, providing the foundation on which to build other mechanisms for global health security had been deliberately ignored in WHO's advocacy.

Ndlovu-Gatsheni (2020) added to argue that knowledge systems that have plunged the world into its current civilizational crisis cannot be the same knowledge systems that hold capacity to take the world out of its present crisis and into the future. That just like the global financial crisis before COVID-19 successfully took the world by surprise; this confirmatory evidence is enough to show that there is an epistemic crisis. A crisis of knowledge which confirms that prevailing knowledge systems of the past five hundred years are no longer capable of predicting challenges and problems as they come, let alone being able to successfully protect people from health emergencies. Wallerstein (2004, p. 58) noticed this epistemic crisis when he introduced the concept of "uncertainties of knowledge" and postulated that "we live in a very exciting era in the world of knowledge, precisely because we are living in a systemic crisis that is forcing us to reopen the basic epistemological questions and look to structural reorganizations of the world of knowledge".

III. CONCLUSION

The study's findings reiterate that the medical history of infectious disease epidemics, including COVID-19, in rural Nigeria is not given form by the interaction of forces internal to the tribal nations that made up rural Nigeria, but by forces operating on the global system. In this way interventions for infectious diseases' emergencies in rural Nigeria had always been framed from the perspective of colonial medicine. Consequently, this distorts and erases narratives of the capacity and autonomy of rural Nigeria to effectively respond to health emergencies. Thus, the handling of infectious diseases' emergencies in rural Nigeria is characterized by discernible secrecy; it is non-curative; urban-based and aims at serving the medical needs of very important personalities (VIPs) or the ruling class, its servants, and immediate dependents. The focus of public health in rural Nigeria emphasizes capacity building for community health workers in handling health emergencies and to ensure access to treatment and vaccination, this focus is not due to the benevolence of the Global North, but this serves as a maintenance-plan that ensures the espousal of the belittlement and exclusion of the narrative autonomy of rural Nigeria to rely on community-based solutions to handle infectious diseases' emergencies. This coloniality expressed in capacity building for community health workers to facilitate community-led solutions to infectious diseases' emergencies only spearheads local level behavioural changes without capacitating local community influencers and leaders on how public health practices, from epidemiological modelling to outbreak containment, help to perpetuate global inequalities. Thus, public health has evolved to only manage and maintain global health inequity in rural Nigeria. Accordingly, capacity building to facilitate indigenous-led solutions to infectious diseases' emergencies in rural Nigeria should be focus at unsettling webs of meaning and power in global health, rather than just interrogating local social norms, attitudes, behaviours and practices in rural Nigeria. Providing capacity building for communities within rural Nigeria whose content prioritizes the empowerment of local community influencers and leaders on how public health practices perpetuate global inequalities is therefore a policy imperative.

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