COVID-19 в Африке

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The light from the stern: South African historians in the era of COVID-19

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Abstract. South Africa was among the few countries on the African continent where medical historians were often called on to reassure the public that the new pandemic could be contained and that lockdowns were bound to end. During the coronavirus pandemic, the role of South African medical historians has been to put historically informed perspectives on the virus outbreaks and their consequences.

For 750 days, South Africa remained in a national state of disaster because of the COVID-19 pandemic. The imposition of lockdown in 2020 increased hunger and poverty, deprived more South Africans of their income and access to education, placed a heavy burden on the healthcare and public health sector, sparked off protest and looting of shops, caused excessive use of violence by security forces and worsened the recession. The pandemic exacerbated the disparities in health, living conditions and access to professional medical services.

Epidemics affect all spheres of people's lives and lead to noticeable social change. The study of epidemics puts the past in a different perspective by foregrounding historically important tendencies and processes. Therefore, the popular media in South Africa sought the opinion of the leading experts in this field, such as Howard Phillips, on the coronavirus disease throughout the state of disaster period.

The impact of the public scholarship by Phillips and his colleagues during the coronavirus pandemic in South Africa demonstrates that knowledge gained from historical research can help people to make sense of the present, which is crucial 'in a time of plague'. That is, historical knowledge can be useful in solving today's problems. Uncovering patterns of responses to epidemics by previous generations of South Africans throughout the centuries, medical historians helped the nation realise that it had already been in dangerous waters before, survived, recovered and might do it again.

Keywords: South Africa, coronavirus, pandemic, COVID-19, Howard Phillips, history of medicine

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Свет из прошлого: южноафриканские историки в период *COVID-19*

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Резюме. В течение 750 дней в ЮАР действовал режим «бедственного положения» (*state of disaster*) из-за пандемии *COVID-19*. ЮАР была одной из немногих стран на Африканском континенте, где СМИ часто обращались к историкам медицины, чтобы заверить общественность в том, что новую пандемию удастся взять под контроль и карантинные меры в обозримом будущем будут отменены. Во время пандемии коронавируса роль южноафриканских историков медицины заключалась в том, чтобы представить исторически обоснованные взгляды на массовые вспышки болезней и их последствия.

Ключевые слова: ЮАР, коронавирус, пандемия, *COVID-19,* Говард Филлипс, история медицины

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INTRODUCTION

On 5 March, 2020, the Minister of Health announced that the first COVID-19 case had been confirmed in South Africa. Just six days later, on 11 March, Howard Phillips, Emeritus Professor of the University of Cape Town, published an article "Containing COVID-19: SA must learn from the mistakes of the 1918 Spanish flu epidemic" [7]. This widely reproduced piece, probably the first reaction by a South African medical historian to the new pandemic, established Phillips as an authority on coronavirus beyond the academia. Given the strong need for objective analysis of the epidemiological situation and credible long-range forecasts, the popular media sought his opinion on the new disease [11].

During the COVID-19 pandemic, the role of South African medical historians has been to provide such a comparative perspective. Being aware of the previous generations' experiences in surviving and fighting lethal viruses helps South Africans to see that, although the coronavirus is new, the situation is not. 'We are not living in unprecedented times. Far from it', remarked a journalist after an interview with Phillips [10].

CONTEXTUALISING COVID-19

In September 1918, two steamers, the *Yaroslavl* and the *Voronezh*, docked at Cape Town. The British-built ships had once been Russian. Commissioned by the Russian *Dobrovolny Flot* (Volunteer Fleet) in the 1890s, the passenger/cargo steamers plied the route from Russia's European ports to Vladivostok. During the First World War, after the new Bolshevik government signed a separate peace treaty with the Central Powers in March 1918, Britain, Russia's former ally, requisitioned the *Yaroslavl* and the *Voronezh* in compensation for wartime debts.

The British government operated the vessels through the Royal Mail Steam Packet Company [1, pp. 48-50, 59-60]. Carrying the South African Native Labour Corps on their way back from Europe, the *Yaroslavl* and the *Voronezh* called at Freetown (Sierra Leone), a hotspot of 'Spanish' flu. The virulent strain of the virus spread among the soldiers aboard the two troopships and, on arrival in Cape Town, across South Africa, as the demobilised men travelled home by train.

A century later, the devastation caused by the 1918 influenza in South Africa was alluded to by the cabinet member who oversaw the country's anti-coronavirus campaign. When a national state of disaster was declared in South Africa, Minister of Cooperative Governance and Traditional Affairs Nkosazana Dlamini-Zuma held a media briefing on the spread of COVID-19. She warned South Africans that the new, poorly studied virus could be especially dangerous:

'The world and our nation have not been faced by such a potentially daunting challenge since the 1918 Spanish flu and the 1932 Great Depression', she noted, 'You will recall that the Spanish flu decimated more than 300 thousand South Africans over a two-year period' [2].

The minister did not mention her historical sources. Her wording implied that the data on the fatality of the 1918 influenza in South Africa was common knowledge. It was hardly so, but the reading public in South Africa was well served by medical historians indeed.

The estimates of the 1918 influenza mortality in Dlamini-Zuma's speech were borrowed from the writings of Professor Howard Phillips (see, for example, [3, p. 81; 4, p. x]). He has long explored the country's epidemic past and taught the social history of public and community health at the University of Cape Town. Phillips' studies of the history of epidemic diseases in South Africa have reached beyond academia. His public scholarship became topical during the coronavirus pandemic.

Historical epidemiology views epidemics and their effects within their social, cultural and economic contexts, enhancing the biomedical understandings [5, p. 10]. Phillips has consistently taken this approach, showing how epidemics can 'test every aspect of a society to its limits, starkly reveal its underpinnings and fault-lines and initiate or accelerate changes' [6, p. 4].

Since the start of the COVID-19 pandemic, Phillips' work has been mentioned hundreds of times by the leading South African newspapers, magazines and news websites. Journalists and academics have referred to and enthusiastically recommended his works, quoting from his collection of memoirs of the 1918 influenza survivors. His articles and interviews appeared not only in academic journals but also in the popular media. South Africa was among the few countries on the African continent where medical historians were often called on to reassure the public that the new pandemic could be contained and that lockdowns were bound to end.

A COMPARATIVE PERSPECTIVE

For 750 days, South Africa remained in a national state of disaster because of the COVID-19 pandemic. The imposition of lockdown in 2020 increased hunger and poverty, deprived more South Africans of their income and access to education, placed a heavy burden on the healthcare and public health sector, sparked off protest and looting of shops, caused excessive use of violence by security forces and worsened the recession. COVID-19's effect on the economy and society was 'immediate, deep and visible' [8, pp. 147-148].

In reference to the state of disaster period, President Cyril Ramaphosa said that it was 'an extraordinary situation that is unprecedented in our country's history' [9]. He was right about the consistent and long-term lockdown measures that his government carried out. But, as medical historians have demonstrated, at least 6 pandemics raged on the current territory of South Africa in the past 400 years, with dire consequences.

Epidemics affect all spheres of people's lives and lead to noticeable social change. Nevertheless, they 'loom small in accounts of South Africa's past, almost in inverse proportion to the anxious attention they attracted while they raged' [3, p. 9]. South Africans are generally ignorant of their epidemic past; therefore, they find it hard to anticipate and prepare for the immense risks that outbreaks of virulent diseases tend to entail. South Africa has one of the highest HIV/AIDS prevalence rates in the world, but the disease has become 'normalised', because antiretroviral therapy has made it possible to manage the syndrome. HIV/AIDS has been seen as a chronic illness, arousing far less fear and anxiety in South African society than it once did.

'This lack of a comparative perspective has, on the one hand, fuelled fear and foreboding among some of what may happen', Phillips commented during the coronavirus lockdown, 'while it has made it difficult for others to conceive of how great a threat a pandemic can pose to society and its everyday functioning' [6, p. 10].

LESSONS OF 'SPANISH' FLU

Considering the coronavirus crisis historically, Phillips stated that his country did not see such extensive effects of a pandemic since the arrival of the 1918 influenza. Comparisons with the Great Influenza were common in the international media in 2020, and they seemed particularly ominous in South Africa. The disease caused by the H1N1 influenza A virus took the lives of three hundred thousand South Africans within six weeks in September and October 1918. The country's population was diminished by 6%. In Phillips' opinion, it was 'the worst single disaster in the country's demographic history' [12, p. 73]. Most of the deaths were caused by pneumonia, a complication associated with both influenza and, a century later, with COVID-19.

During the state of disaster of 2020-2022, the death toll never reached the proportions of the 1918 disaster. Nor did the coronavirus pandemic cause emotional traumas on a comparable scale. However, as noted by Lindie Koorts, a South African historian, the COVID-19 crisis lasted longer, 'requiring sustained behavioural adjustments and restrictions that fall outside the scope of people's memory' [13]. Phillips' audiences were better prepared for it than other South Africans because he correctly assumed that, even after an effective vaccine was developed, the new pandemic would remain part of people's lives for several years.

Phillips argued that the early 20th-century epidemic offers important lessons that 21st-century South Africans must learn to avoid a catastrophe. The speed and modes of travel have changed substantially, but the spreading of viruses and the human responses to it have not. Human mobility (tourists and travellers, sailors and salesmen, migrants, refugees and returning soldiers) has brought global pandemics to South Africa for centuries, and the coronavirus is no exception [14, p. 12]. In the globalised world, viruses can be transmitted faster, with their hosts travelling by car or jet airliner rather than by ship or steam train.

The historian welcomed the national lockdown, which started on 27 March, 2020, just three weeks after the first confirmed COVID-19 case in the country. Viewing this measure as a necessity to prevent the disease, he encouraged South Africans 'to bite the bullet now if you do not want to bite the dust in a month's time' [15].

The 1st wave of the 'Spanish' influenza in South Africa was comparatively mild, which led the authorities to underestimate the threat. Therefore, during the far more serious 2nd wave, in the 'Black October' of 1918, they failed to prevent the virus from engulfing the country within weeks. The soldiers returning from Europe, who hosted the H1N1 influenza A virus, were released from quarantine too soon after their disembarkation in Cape Town and were allowed to return to their homes, carrying the virulent strain and transmitting it to others. Half of the population contracted the disease within a month [4, pp. x-xii, 1].

When dealing with the coronavirus, the government had to avoid tragic mistakes of the past. Phillips called for a swift, decisive action and strict implementation of precautionary measures, emphasising the need for a quarantine for the infected and their contacts. In the absence of a vaccine, isolation and social distancing could stop the virus from spreading.

Within the two months after the first confirmed case was reported in South Africa, the government took comprehensive measures to combat SARS-CoV-2. South Africans were ordered to stay at home. Going outside was allowed only to buy essentials or in emergency. The public health authorities promoted regular hand washing and sanitising. Handshaking, which helped to spread the virus, was being replaced with elbow bumps and other forms of greeting. In Phillips' opinion, those were positive developments. By contrast, when people or communities isolated themselves in 1918, it was self-imposed rather than enforced by the central government. During the influenza outbreaks, the quarantine was never strict, and heightened hygiene measures were rarely taken. Together with rather cursory medical examinations, they were unable to prevent the 'Spanish' flu from claiming more lives.

The South African government's reaction to the pandemic was characterised by anticipatory action to lighten the burden on the health system. 'Putting out the small flames to avoid a raging fire' was the main principle in fighting the coronavirus. To identify COVID-19 cases and minimise community transmission, mobile testing units and thousands of health workers, some already employed in HIV- or tuberculosis prevention, were deployed in areas with the highest population density and, correspondingly, the highest risk of infection. Residents showing coronavirus symptoms were identified and treated, and their contacts quarantined. By minimising or preventing community transmission in high-risk areas, the doctors succeeded in maintaining a comparatively low infection rate during the 1st wave [17, pp. 58-59].

Over the following two years, the country survived three other waves of the epidemic, with higher infection rates. During the 3d wave, in July 2021, Johannesburg hospitals were said to lack beds and oxygen for coronavirus patients as the public health system in South Africa's largest city was stretched to the limit. After each wave, some

restrictions were eased, only to be tightened or reimposed several months later with the new tide of coronavirus cases. The national state of disaster endured, which involved mask wearing, social distancing and limitations on public gatherings and international travel even while the number of cases temporarily declined.

The last, 4th wave in the state of disaster period had begun by December 2021 after the Omicron variant of SARS-CoV-2, which had a much higher rate of spread than the earlier variants, was first reported to the World Health Organization from South Africa.

ADVANCES AND DRAWBACKS

In 1918, the medical profession could offer only palliative remedies and support natural recovery because the influenza virus had not been identified, and antivirals did not exist yet. However, biomedicine has become the preferred system in South Africa, guiding the government's public health policies. Its acceptance by South Africans has been strengthened by its success in ending or managing the other epidemics in the country with the introduction of vaccines against smallpox or polio and anti-retroviral drugs against AIDS [6, p. 13].

Indeed, in February 2021, South Africa started a COVID-19 vaccination programme, the largest of its kind in the country's history. The previous mass campaign (1955-1961) was designed to immunise white children, who were particularly vulnerable to polio; less than a million South Africans were given a polio vaccine. By contrast, over 20 mln people had been vaccinated against the coronavirus in South Africa from late February 2021 to early April 2022.

By the end of the state of disaster in April 2022, 35% of South Africans had been vaccinated against COVID-19. Although it exceeds the average share in Africa (21%), it is less than the vaccination rates in other countries of the subregion, such as Botswana (61%), Mozambique (45%) or Zimbabwe (37%), whose health facilities are less developed. The campaign was hampered by vaccination hesitancy and scepticism, which, according to Phillips, had 'deep roots' in South African epidemiological history. In his interviews, the historian emphasised that the programme depended on the people's trust not only in biomedicine but also in the government and the public health system. Another major barrier, identified by the University of Johannesburg researchers, was related to social inequality: people in informal settlements and in the country found it hard to reach vaccination sites, which tended to be located in richer urban areas [18].

Shortly after the 'Spanish' flu outbreaks of 1918, the South African government set up a Ministry of public health to provide reliable information to the public, so that they were no longer ignorant about new epidemics. Still, its successor, the post-apartheid Department of Health, despite its regular public statement and briefings, was unable to fully persuade the public that it knew how to deal with COVID-19, particularly in the first year of the pandemic. Social media users peddled misinformation on the origins and fatality of the new virus to compensate for the lack of officially endorsed, biomedically proven information. It was a way for South Africans to reduce the uncertainty and prepare for what lay ahead.

Phillips' collection of interviews with survivors of the 'Spanish' flu epidemic was widely publicised during the COVID-19 lockdowns in South Africa. Although the book's popular appeal was limited because of its academic character, the testimonies of the 1918 disaster evoked the fear and disorientation that echoed the prevalent moods in the state of disaster period a century later. Phillips stated that the social crises caused by epidemics 'call forth raw responses and emotions unvarnished by political correctness or cosmetic politeness' [3, p. 154].

Epidemics always revealed prejudices, and, in such situations, South Africans tended to accuse other racial or ethnic groups of bringing the virus into the country and spreading it unknowingly or even intentionally. It was particularly dispiriting to witness such tendencies in the post-apartheid South Africa where 'the mantra of social cohesion has been superseded by that of social distancing' [19].

On the other hand, many South Africans responded to the new pandemic with outstanding expressions of altruism. As in the previous health crises in that country, their efforts transcended racial divisions. Large South African companies and some of the richest South Africans made sizeable donations to the Solidarity Fund, a public benefit organisation that supported the national relief programmes for the most vulnerable communities.

SOCIAL RELIEF

Phillips also foresaw that the authorities would be motivated to take swift action to improve the poor living conditions of millions of South Africans, which make it hard for them to comply with the lockdown regulations. Most of them have jobs in the informal sector, which offers no social benefits but requires them to leave them homes regularly and interact with their customers in public places. They spend many hours daily in overcrowded and unsanitary environments at home, at work or aboard public transport, and their immune systems are compromised. A study revealed that the COVID-19 fatality rate was twice as high in low-income communities as elsewhere in Cape Town [20].

The pandemic exacerbated the disparities in health, living conditions and access to professional medical services, affecting the most susceptible in South African communities hardest. This realisation prompted President Ramaphosa's commitment 'to forge a new economy and not merely return the economy to where it was before COVID-19 struck' [19].

But Phillips, based on his research on the epidemiological history of South Africa, concluded that the enthusiasm for social and economic upliftment of the disadvantaged tended to wane shortly after a public health crisis is resolved, undermined by the socio-political realities [20]. At the same time, he drew his readers' attention to 'an unprecedented roll-out of social relief by the state to the unemployed' which accompanied the strict lockdown measures [19].

Millions of South Africans badly needed government assistance as unemployment rose from 29.1% before the pandemic to 35.3% at the end of 2021. It was the highest rate in fourteen years [21, p. 2; 25, p. 6]. The government tried to salvage the South African economy by reallocating a large part of the budget and securing soft loans from international financial institutions for a stimulus package that amounted to 10% of the country's GDP [17, p. 58]. It was used to minimise the damage that the pandemic and the restrictions inflicted on the economy in recession and to compensate for the income losses of the most disadvantaged residents.

To stifle the growth of poverty and inequality, the government greatly expanded social protection. It introduced temporary relief schemes for small businesses and employees who lost jobs in the formal sector. Over 6 mln people, who had not received social grants before and did not qualify for the relief schemes, benefited from the new COVID-19 Social Relief of Distress grant (350 South African rands / USD22).

The cash-based COVID-19 relief measures reached half of the country's population. Besides, South Africa was among the few countries on the continent which expanded their social protection programmes to cover informal workers, because they were particularly vulnerable to the effects of the pandemic [23, pp. 2-4; 24, p. 1232].

STATE OF DISASTER ENDS

In March 2022, South Africa had the highest number of confirmed cases of COVID-19 in continental Africa. However, ratios are more important for understanding the epidemiological situation. Calculated as a total number of cases per million residents, the South African COVID-19 infection rate was significantly lower than that in Botswana, Libya and Tunisia.

On this basis, the infection rate in South Africa was comparatively low, the 127th highest in the world. The coronavirus fatality rate in that country (2.7%) exceeded the worldwide average (1.2%). In deaths per million, South Africa was ahead of Namibia, Eswatini, Botswana and Libya, and second only to Tunisia in continental Africa. But it was precisely these countries (apart from Gabon and Rwanda) that had the highest rates of COVID-19 testing on the continent [25; 26]. Apparently, the data from other African countries on coronavirus deaths and cases is not as representative because of their significantly lower rates of testing.

By late March 2022, it had become obvious both to the public and to health professionals in South Africa that the four waves of COVID-19 proved to be far less fatal than the three waves of the 1918 influenza a century before. In South Africa, deaths constituted only around 3% of the number of infections. The COVID-19 death toll within the two years of the new pandemic (under 0.2% of the country's population) did not match the horrifying mortality of the 'Black October' of 1918 (an estimated 6% of the population).

Although the number of infections in the 4th wave exceeded that in each previous wave, the public health authorities recorded fewer cases of severe illness and COVID-related deaths. There was also a marked reduction in coronavirus hospitalisations and ICU treatment. 'Many people express exhaustion around COVID, with sentiment that the virus is now very weak and COVID is over', noted the Department of Health, pointing out to pandemic fatigue, 'There is questioning why we are still prioritising COVID' [27, p. 2].

The government decided that the requirements for a national state of disaster were no longer met. It acknowledged that the pandemic had not ended, but there was no longer a need for prolonged emergency measures. Announcing the termination of the state of disaster from 5 April, President Ramaphosa assured South Africans that 'we are in a better position now than we have been at any other time over the last 750 days.' [9]. Nearly all coronavirus regulations were repealed, with the remaining restrictions to be lifted a month later.

THE ROLE OF A HISTORIAN IN TIMES OF CRISIS

The American medical historian Roderick McGrew believes that epidemics have highlighted 'normal aspects of abnormal situations', intensifying existing behaviour patterns that 'betray deeply rooted and continuing social imbalances' [28, p. 71]. They accentuate socio-cultural attitudes, accelerate trends and draw attention to the society's deficiencies. The awareness and sense of urgency bring about social change. Past epidemics shaped South Africa's history, contributing to the development of the healthcare and public health system, altering the demographic

structure of the colonial society, and enabling politicians to lobby forced removals and racial segregation as epidemic expediency [3, p. 153; 22].

The study of epidemics puts the past in a different perspective by foregrounding historically important tendencies and processes. However, it is yet to be seen if the COVID-19 pandemic would stimulate historians to fully appreciate the significance of diseases and their consequences for the making of South African history.

In the short term, the coronavirus experience will influence pandemic and disease scholarship. It is unlikely that the coronavirus would replace plague 'as the quintessential pandemic concept in historical thinking' [29, p. 1665] if the COVID-19 fatality rates remain comparatively low. At the same time, living through the lockdowns may prompt historians to shift their focus to the microlevel by exploring how epidemics have affected individuals and small communities rather than the society in general.

We may see projects similar to Phillips' *In a Time of Plague*, which is based on his interviews with survivors of the 1918 influenza. He has also advocated incorporation of epidemic history into school syllabuses and university courses to help South African society to manage outbreaks of virulent viruses in the future [6, p. 10].

The impact of the public scholarship by Phillips and his colleagues during the coronavirus pandemic in South Africa makes me think of the question of usefulness of history. The prevailing view on this subject was articulated by the British historian and philosopher R.G. Collingwood, who stated that the purpose of history is self-knowledge. Knowing what people have done indicates what they can do, which is the key to self-knowledge.

According to Collingwood, history teaches us 'what man is' [30, p. 10]. But why do we need self-knowledge if people hardly learn from history? In the words of the English poet, S.T. Coleridge, 'passion and party blind our eyes, and the light which experience gives is a lantern on the stern, which shines only on the waves behind us!' [31, p. 380].

The German philosopher G.W.F. Hegel asserted that history's lessons were useless because recollections of a past experience 'are powerless before the stress of the moment, and impotent before the life and freedom of the present' [32, p. 21]. Each generation finds itself in situations that its predecessors never faced, and unique circumstances require unique solutions. Later intellectual historians have pointed up that mindfulness of the divide between the past and the present is critical.

The American scholar A.Megill remarks that historians, instead of trying to establish continuity between the past and the present, should focus on the past as 'a reservoir of alternative possibilities, of paths not taken, of difference' [33, p. 11]. History's utility is in satisfying existential needs, such as in letting us see our life as part of human history and revealing the multitude of possible ways of understanding the world.

The Russian intellectual historians B.G. Mogilnitsky and M.A. Barg believed that history's status as an academic discipline was justified only if historians aspired to generalisations, which allowed them to discern patterns of change. History cannot teach or prognosticate, but its findings can help to identify trends in social change and development. There is continuity between the past and the present, despite the many gaps, breaches and variations in historical processes. The more the present differs from the past, the more we need to understand the past to adapt to the rapidly and drastically changing situations in the present [34, p. 56; 35, p. 20].

Indeed, too often 'usefulness' in history has been associated with conformism, propaganda, inattention to historical evidence, and political and ideological interventions. All the same, historical knowledge can help people to make sense of the present, which is crucial 'in a time of plague'. Phillips' work in 2020-2022 shows that history can be useful in solving today's problems, without extrapolating the impact of the COVID-19 pandemic from South Africa's epidemic past.

CONCLUSION

Medical historians in South Africa during the national state of disaster performed an important social task. Uncovering patterns of responses to epidemics by previous generations of South Africans throughout the centuries, they helped the nation realise that it had already been in dangerous waters before, survived, recovered and might do it again. Phillips and his colleagues did not try to predict the future. Instead, they let the lantern of history light the waves, so that the nation's ship no longer sailed in pitch darkness.

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