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The Black Diaspora and Africa's COVID-19 Response: Transnational Solidarities, State Engagement, and the Ghanaian Experience

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Abstract

Pandemics are recurring historical phenomena that have shaped societies globally, yet scholarship on COVID-19 has largely centred on biomedical explanations, often marginalizing African perspectives and state responses. This study addresses this gap by examining African interpretations and responses to COVID-19, with particular reference to Ghana within a global historical context. The study adopts a multidisciplinary historical approach, drawing on primary sources including interviews, oral testimonies, archival repositories, government addresses, and print media, alongside secondary literature from history, public health, and the social sciences. Qualitative and comparative analysis is employed. Findings reveal that Africa's COVID-19 response was shaped by historical memory, political leadership, communal ethics, and diasporan engagement, influencing public compliance and policy outcomes. The study underscores the importance of culturally grounded public health strategies and inclusive governance, offering critical lessons for pandemic management in developing countries.

Keywords: Africa; Diaspora; COVID-19; Pandemics; Public health; Responses

INTRODUCTION

The moment when a security officer routinely measures the temperature of a medical doctor at the entrance of a public institution is emblematic of the profound rupture introduced by the COVID-19 pandemic. Such practices signal not merely a biomedical emergency but a broader historical transformation in everyday governance, social relations, and perceptions of risk. Yet, while COVID-19 has been widely framed as an unprecedented crisis, history reminds us that pandemics are neither anomalies nor novelties. Thus, this new normal is not entirely new in the historical context (Habicht *et al.*, 2020). From the Plague of Justinian in the sixth century through to the Black Death in the fourteenth century, influenza pandemics have recurrently reshaped societies, knowledge systems, and political authority. Across history, pandemics have repeatedly plunged societies into crisis, crippling economies, undermining infrastructure, escalating unemployment, eroding public trust, and diminishing collective hope. Thus, historical memory, therefore, remains central to understanding present crises and anticipating future ones. As Amadi's work has pointed out that human destiny and the extent to which it can be changed, and the relationship between people and their gods in a society are determined by circumstantial occurrences

(Amadi, 1969). Similarly, expressions are found in Patterson (1995), Ziegler (1999), Kelly (2006) and Cantor (2001) who generally conclude that plagues, in particular, are both transformative and reformative. Overall, the articulations on responses to infectious diseases among Africans and its Diasporan society remain to be studied. Suffice it to say that the staple of animated queries, arguments, observations, and conclusions of the large portion of literature on worldwide outbreaks since the Justinian Plague and the Black Death, there is a manifest neglect of Africa and its Diasporas' perspectives on and responses to such global pandemics. Yet contemporary pandemic scholarship still treats this as peripheral, but rather has made significant advances in identifying the transmission dynamics and structural determinants of pandemics. For example, whereas Zhu *et al.* (2020), Islam *et al.* (2021) and Coccia (2022a) from their respective studies demonstrate that viral diffusion is shaped by a complex interaction of climatic variables such as temperature and humidity, findings by Rahimi *et al.* (2021), Coccia (2021), Diao *et al.* (2021), and Askitas *et al.* (2021) point to environmental conditions including air pollution, population density and mobility as key transmission indicators. Bontempi and Coccia (2021), on the other hand, see global economic integration, particularly international

trade and travel networks as unavoidable dynamics. On prevention and control, Flaxman *et al.* (2020), Benati and Coccia (2022) assert that public policy responses, especially non-pharmaceutical interventions, contact tracing systems, vaccination strategies, and health system preparedness are key indicators of influenza control. Coccia (2023), however, concludes that these control measures further shape pandemic trajectories and outcomes. Comparative analyses across OECD, BRICS, and European states underscore how institutional capacity, technological infrastructure (Coccia, 2023), and fiscal health influence crisis management (Song *et al.*, 2025).

Much of the dominant scholarship, as above, conceptualizes Africa primarily as a site of epidemiological vulnerability or policy diffusion, rather than a producer of ideas, practices, and historically grounded responses to pandemics. Where African perspectives, communal ethics, indigenous knowledge systems are contextualized, Mukolwe *et al.* (2025) and Montcho *et al.* (2025) observe that analyses often privileged sociological or developmental framings. This marginality leaves insufficient room for historical interpretation. Therefore, charting a new trajectory for the historical study of global pandemics in Africa and its diasporas, this study, using Ghana as an optical prism, explores African perspectives, state responses and transnational Black Diasporan engagement at the instance of the Covid-19 pandemic otherwise known as the 'novel coronavirus'. The study will prove that this pandemic is not novel as it will carry out a tracer study and also examine the recurrent nature of some worldwide outbreaks, which most of the time affect Africa, looking out for specific responses as upheld at the outbreak of viral infectious diseases. The central research questions guiding this study are therefore: How have African historical experiences shaped contemporary perceptions and responses to COVID-19? In what ways have state policies, public discourse, and diasporan engagement reflected deeper intellectual traditions regarding life, risk, and collective responsibility? And how do these African responses complicate dominant global narratives of pandemic governance?

LITERATURE REVIEW: HISTORICAL CONTEXT OF GLOBAL PANDEMICS

There is a vibrant and fascinating history of worldwide outbreaks of influenza dating back to the sixth and fourteenth centuries (Habicht *et al.*, 2020). Africans have had a long history of influenza pandemics. In Iliffe's (2017) view, Africans created their own ideological defences against suffering, and health probably loomed larger in their ideologies than in those of other continents. Thus, Africans generally faced suffering squarely, valuing endurance and courage above all other virtues (Iliffe, 2017). This implies that the African strategy of resilience to sufferings since the creation of village settlements and contacts with the outside world are matters of honour and self-respect. Since the rise of historical scholarship in the twentieth century, historians have often overlooked the enduring role of honour and self-respect in shaping African responses to crises such as slavery, colonialism and rulership. Aside from the Justinian Plague, the plague that devastated Africa and Eurasia was the Black

Death, which ignited a never-ending interest in both scholarly and general readers (Habicht *et al.*, 2020; Glatter and Finkelman, 2021). Much plague scholarship emphasizes demographic and economic impacts, exemplified by studies tracing the Black Death's spread along Asian-European trade routes in contrast to the earlier Justinian Plague, which likely originated in northern Africa and diffused across the Mediterranean and the Pacific society (Zietz and Hartmut, 2004). Quantitative accounts alone cannot capture the lived trauma of pandemics, including fear, moral dilemmas, and the breakdown of social bonds. As Kelly (2006) vividly illustrates, the Black Death spread rapidly across Europe, killing an estimated 75 million people and transforming everyday life with unprecedented immediacy and terror. On their part, Khaldun (1967) and Dols (1977) at separate accounts give a vivid sense of the plague and its demographic impact on the Middle East countries and Africa in general.

Throughout history, pandemics have profoundly shaped human societies, driving social, economic, and political transformation in Africa, the diaspora, and beyond. Recurrent disease outbreaks have not only prompted reform and innovation but also spurred major advances in modern medicine, including epidemiology, vaccination, prevention, and antimicrobial treatments (Khaldun, 1967). Experiences from the Black Death, the 1918 influenza, and recent pandemics such as SARS, Ebola, Zika, and COVID-19 reveal the social, medical, and psychological impacts of infectious diseases. These events demonstrate that Africa and its diasporic communities, across regions and generations, are intrinsically connected to global pandemics, with shared experiences and consequences that shape collective responses and cannot be underestimated. Thus, infectious diseases in human history have deepened the understanding of how societies perceive and respond to global disease outbreaks. Together, these events help shape collective responses. For example, the three worldwide outbreaks of influenza which occurred in the twentieth century and had great impacts on Africans include the 1918–1920 Spanish flu, the 1957–1958 H2N2, and the 1968 H3N2 (Sandra, 1994; Patterson, 1995). Past influenza pandemics have shaped contemporary African perceptions of pandemics, particularly those occurring in the era of modern virology. The Spanish flu, alongside the Asian and Hong Kong influenza outbreaks, advanced modern medicine and epidemiology and were later identified as H1N1, H2N2, and H3N2 strains (Rath, 2024; Singh *et al.*, 2025). These viruses entered African communities largely through weak border surveillance.

In the Gold Coast, early colonial correspondence warned Accra of infected ships arriving during the 1918 influenza outbreak, illustrating early awareness of transregional disease transmission (Patterson, 1995). This warning, according to Patterson, came in too late and that the S.S. Shonga, an American vessel outbound from Freetown, reached Cape Coast on August 31, 1918 (CDC, 2010a). The Shonga became the source from which the disease with multiple infested sailors spread to other parts of the colony and between September 3 and 25, 1918, the virus had plague-ridden a great number of communities in the Western, Eastern and Central Provinces, with the Northern Territories

recording cases by October 8 (CDC, 2010b). Analysing the outcome of the Spanish Flu in 2018, Kitaw and Kaba (2018) describe it as devastating as the upshots of the influenza virus in Ethiopia in 1918. The flu, according to their report, raised havoc on the populace with scores of deaths, with the capital city, Addis Ababa, happened to suffer the most. In similar narratives, Patterson (1995) gives a vivid account of how the 1918 influenza flu ravaged the residents of the Gold Coast. Patterson's (1995) assertion corroborates an earlier colonial official report in an extract, thus:

"The disease had become widespread in the capital within two weeks of the landing of the sick sailors from the Shonga. As the infection spread, the markets dwindled, schools closed, public meetings were cancelled and normal businesses came to a standstill. Waterfront district was hard hit; cocoa loading was delayed and ships by-passed Accra" (PRAAD, 1918; Patterson, 1995).

The extract above is a clear manifestation that the spread and effects of not only the Spanish flu but also other related influenza outbreaks, were not only limited to the Gold Coast at the time but had similar devastations across the continent. This unnoticed tittle-tattle, or if you like, perspectives on outbreaks on the part of affected communities within the African setting, is a key element of disease outbreaks which has very often eluded the attention of historians and scholars alike.

Since the 1920s, which marked the disappearance of the Spanish flu, Africa's relationships to infectious diseases have taken a dramatic turn, particularly at the outbreak of malaria, Lassa fever, Marburg, MDR/XDR Tuberculosis, HIV/AIDS, Zika, Dengue, Middle East respiratory syndrome (MERS), severe acute respiratory syndrome (SARS), and Ebola (Green, 2015). Colonial official reports have shown that many other influenza diseases occurred in the twentieth century, though not classified as true pandemics, but the three notable epidemics are the pseudo-pandemic between the 1930s and 1940s with very minimal death rates (PRAAD, n.d.a), an epidemic in 1977 that was a pandemic in children following an abortive epidemic of the swine influenza in 1976 that was feared to have pandemic potential. Mention can also be made of the Nipah virus of 1999, which was later listed by WHO as a global epidemic threat (Branda *et al.*, 2025). Major influenza epidemics show no predictable periodization or pattern, and all differ from one to the other. For example, the 2009 H1N1 pandemic, though less severe than the 1918 flu, demonstrated the continued vulnerability of global populations to novel influenza strains (Fineberg, 2014; Dawood *et al.*, 2012). Similarly, the HIV/AIDS pandemic has had a devastating and prolonged impact on Africa, shaping health systems and social responses for decades (Ciesla and Roberts, 2001).

Notwithstanding the reviews above, comparative analytical studies by such scholars in recent time as Matlata (2025), Musah *et al.* (2025), Otekunnin (2025), Markhof *et al.* (2025), Petersen *et al.* (2025), Wimba *et al.* (2025), Amevor (2025), Coccia and Benati (2024), provide insights into the defects or otherwise of national health policies, strategies and plans for pandemics, particularly COVID-19 among regions.

One significant missing link in all of these scholarships is the lack of attention to the perspectives and responses by citizens on pandemic outbreaks.

METHODOLOGY

Design

The study uses a qualitative historical, multidisciplinary approach, drawing on intellectual history, African historiography, public health history, and media studies to interpret African and Black diasporan perspectives on COVID-19 as historically shaped responses grounded in memory, ethics, and governance experience.

Document Search and Selection

Data were drawn from both primary and secondary documentary sources. Primary sources included government documents and official communications, print and electronic media reports from Ghana and selected international outlets, and diasporan communications such as opinion pieces and public statements. Oral interviews and informal testimonies from healthcare workers and community members were also consulted to capture the lived experiences of the pandemic. Archival documents such as medical and sanitary reports and correspondence at the Public Records and Archival Administration Department (PRAAD) were accessed and interrogated. In Accra, data from which information was obtained includes files of the Colonial Secretary's Office classified under the CSO/11 Series.

Data Extraction

Relevant data were systematically extracted from selected documents, focusing on recurring themes such as perceptions of disease origin and spread, state authority and public trust, quarantine and contact-tracing practices, communal ethics, diasporan intervention, and the moral framing of life versus economic survival. For historical sources, attention was given to patterns of continuity and change in responses to epidemic disease across time.

Data Analysis and Synopsis

Data were analysed through a thematic and interpretive historical approach, using comparative readings and historical analogies to situate COVID-19 within longer trajectories of disease management, highlighting how African responses were shaped by structural conditions, historical memory, and diasporan engagement.

RESULTS AND DISCUSSION

Origins, Global Spread and the Ghanaian Context

The origins of COVID-19 trace back to Wuhan, China, where a cluster of pneumonia cases of unknown etiology was reported in December 2019 (Rosario *et al.*, 2020). On 12 January 2020, the World Health Organization (WHO) confirmed a novel coronavirus, later designated SARS-CoV-2, as the cause of COVID-19 (WHO, 2020). Coccia (2022b), Nunez-Delgado *et al.* (2021) and Yuan *et al.* generally hold the view that the virus spreads primarily through respiratory droplets and manifests clinically as fever, cough, fatigue, and acute respiratory distress, with complications including

pneumonia. By May 2020, COVID-19 had caused over five million infections globally, including more than 7,000 confirmed cases in Ghana (JHU, 2021). Prior to detection, Ghana implemented preparedness measures, including surveillance strengthening, border screening, contact tracing, and public education (GOG, 2020). Enhanced testing, digital surveillance tools, and community-based tracing contributed to identifying predominantly asymptomatic cases, underscoring the effectiveness of early intervention strategies (GHS, 2020). SARS-CoV-2 shares its genetic similarity to the SARS virus that caused an outbreak in 2002 (JHU, 2021). Rosario *et al.* (2020) assert that the zoonotic origins of the virus, possibly linked to a wet market in Wuhan, underscore the complex interplay between human activity, environmental degradation, and emerging infectious diseases.

The initial response to the outbreak in Wuhan was marked by a mixture of public health measures and delayed action, which allowed the virus to spread beyond China's borders. By January 2020, cases were reported in Thailand, Japan, and South Korea, marking the beginning of the virus's global dissemination (IMF, 2021; WB, 2021). Globalization accelerated COVID-19's spread, highlighting global interconnectedness. Countries responded with varied strategies, from strict lockdowns to herd-immunity approaches, revealing weaknesses in health systems and early shortages of PPE, ventilators, and testing kits (Bloom *et al.*, 2018; Gates, 2020). The strain on healthcare systems led to a dramatic increase in mortality, particularly among vulnerable populations such as the elderly and those with pre-existing health conditions. Globally, the case fatality rate varied significantly, influenced by demographic factors, healthcare capacity, and public health responses (Jit and Choi, 2006; Moghadas *et al.*, 2020).

Economically, the impact was also profound (Lancet COVID-19 Commission, 2021). Global supply chains were disrupted, leading to shortages of goods and services. Lockdowns and social distancing measures resulted in significant job losses, particularly in sectors such as tourism, hospitality, and retail. The International Monetary Fund (IMF) estimated that the global economy contracted by 3.5% in 2020, making it the worst economic downturn since the Great Depression (WB, 2021). The pandemic also exacerbated existing social inequalities, with marginalized communities disproportionately affected by both health and economic consequences of the crisis (WB, 2021). According to Dr. Anthony Nsiah-Asare (2023, personal interview), Ghana's experience of COVID-19 reflected the strengths and limitations of a public health system shaped by colonial legacies and post-independence reforms. While initiatives such as the National Health Insurance Scheme improved healthcare access, persistent challenges, underfunding, limited infrastructure, and workforce shortages left the system vulnerable. Historical encounters with pandemics, including the 1918 influenza and endemic diseases like yellow fever, malaria and HIV/AIDS, informed Ghana's public health strategies but also exposed structural weaknesses that resurfaced during the COVID-19 crisis.

The COVID-19 pandemic profoundly affected health, economies, and governance worldwide, with Ghana facing both global and local challenges. Its response, shaped by historical and socio-economic realities, began after its first confirmed cases on 12 March 2020, soon after the WHO declared a pandemic (Gyamfi, 2020; WHO, 2020). Ghana, unlike previous outbreaks, responded swiftly to COVID-19, implementing border closures, mandatory quarantine, and testing and treatment centres, with measures shaped by global strategies and the country's socio-economic context. Ghana's early COVID-19 response featured strong leadership from President Nana Addo Dankwa Akufo-Addo, including partial lockdowns in major cities like Greater Accra and Greater Kumasi, and the creation of a coordinated National COVID-19 Response Team (Akufo-Addo, 2020). As reiterated in both traditional and print media, the use of traditional and social media platforms to disseminate information about the virus and promote public health guidelines was instrumental in raising awareness and encouraging compliance with preventive measures (Asare, 2020; Ofori-Atta, 2020; Yeboah, 2021). Nana Ama Asiedu runs a successful fashion business in London and spoke about how she used her platform to raise awareness and funds for struggling families in Ghana during the lockdown (Asiedu, 2021, personal interview). Social media helped the Diasporas to mobilize remittances and supplies to Ghana, supporting virus containment but highlighting social inequalities. Economic hardships, especially in the informal sector, complicated compliance, while Ghana's limited experience with large-scale pandemics contrasted with prior regional outbreaks like yellow fever, cholera, and Ebola (Asare, 2020). These past experiences, according to Seny Hosi (2021, personal interview) and Mensah (2021), informed the government's approach, leading to early interventions such as the establishment of isolation centres and the ramping up of testing and contact tracing. The Ghana Health Service (GHS), in collaboration with local and international partners, spearheaded these efforts, reflecting a historical reliance on both national and international support during health crises.

A practice that featured prominently during the pandemic was the Derivation of the term Quarantine (PRAAD, n.d.b). Quarantine has long been a central public health practice used to isolate the sick during disease outbreaks. In the 1920s and 1930s, following the outbreak of infectious diseases such as yellow fever, small pox, human rabies, Bubonic plagues, and the likes, colonial official reports indicate that quarantine emerged as a central public health practice during such occasions, and in particular pandemics, with roots predating the term itself (PRAAD, n.d.b). Thus, historical and biblical precedents, notably the isolation of individuals with leprosy in Leviticus 13, demonstrate early recognition of disease containment (The Holy Bible, Leviticus 13:46, Numbers 5:2, 2011). Although the term quarantine does not appear in biblical texts, its practice evolved through recurrent pandemics from antiquity to the medieval period. During the Black Death, organized isolation became more systematic (Sehdev, 2002). In 1374, Viscount Bernabo of Reggio ordered the removal of plague victims from the city until recovery or death, reflecting early quarantine policy (Benedictow, 2004). A similar approach was adopted in 1377

in Ragusa (modern Dubrovnik), where arrivals were subjected to a 30-day isolation period under Jacob of Padua, later extended to 40 days (*quarenta giorni*). This innovation marked a shift from social exclusion to regulated isolation and became one of the few effective disease-control measures, spreading across Europe and into Africa (Tognotti, 2013).

The Dynamics of Global Health Governance

By the time the WHO declared COVID-19 a pandemic on March 11, 2020, the virus had already spread across continents, profoundly impacting nearly every aspect of human life (JHU, 2021). The novel coronavirus, even though not novel in its entirety, has received the most of socio-political commentaries more than it can be gathered for its counterparts in history. It must be emphasized that the 21st century has witnessed several public health crises, with the COVID-19 pandemic standing out as one of the most significant (JHU, 2021). The public health response to the COVID-19 pandemic varied widely across countries, reflecting differences in political systems, public health infrastructure, and cultural attitudes toward health. Aning (2020) and Bofo-Arthur (2021) assert that the initial response to the pandemic in countries focused on containment measures, such as testing, contact tracing, and quarantine. However, as the virus continued to spread, many governments implemented more stringent measures, including nationwide lockdowns, school closures, and mandates for mask-wearing and social distancing (Akufo-Addo, 2020). One of the most significant developments in the fight against COVID-19 was the rapid development and deployment of vaccines. The global scientific community mobilized at an unprecedented pace, leading to the development of several vaccines within a year of the virus's emergence (Gavi, 2021). The Pfizer-BioNTech, Moderna, and AstraZeneca vaccines, among others, were authorized for emergency use in late 2020 and early 2021 (Menon 2024). The rollout of vaccination campaigns was a critical turning point during the pandemic, offering hope for a return to normalcy. However, vaccine distribution was marked by significant disparities, with wealthy nations securing the majority of doses while many low- and middle-income countries struggled to access vaccines (Raymond, 2021).

Ghana's COVID-19 experience exposed longstanding public health challenges rooted in historical inequities, including limited testing, hospital capacity, and PPE, especially in rural areas. Despite these constraints, Ghana demonstrated resilience and innovation, notably by using drone technology to transport test samples from remote communities, improving access to diagnostics and adapting global solutions to local needs. Furthermore, COVID-19 highlighted the importance of global governance and international cooperation in addressing global health crises (Bofo-Arthur, 2021). The WHO played a central role in coordinating the global response, providing guidance on public health measures, and facilitating international collaboration on research and vaccine distribution (WHO, 2021). However, the pandemic also exposed the limitations of existing global health governance structures. Criticisms were levelled at the WHO for its handling of the early stages of the outbreak,

particularly regarding its reliance on information from national governments and its delay in declaring a pandemic (WHO, 2021). The pandemic also strained international relations, with some countries engaging in "vaccine nationalism," prioritizing their own populations over global distribution (Gavi, 2021; WHO, 2021). The COVAX initiative, co-led by the WHO, Gavi, and the Coalition for Epidemic Preparedness Innovations (CEPI), aimed to ensure equitable access to vaccines, but its success was limited by funding shortfalls and supply constraints (Gavi, 2021). The pandemic underscored the need for stronger global health governance mechanisms, including more robust systems for early detection and response to emerging infectious diseases, as well as greater international solidarity in addressing global health challenges (Gavi, 2021).

It is gathered from the above that the economic impact of COVID-19 in Ghana was profound, mirroring the global economic downturn (Akufo-Addo, 2020; IMF, 2021; WB, 2021). As a lower-middle-income, export-dependent economy, Ghana experienced major trade disruptions and declining remittances during COVID-19, worsening existing debt and fiscal constraints and prompting government intervention to cushion the economic impact (Akufo-Addo, 2020; Mensah, 2021). Official reports, which corroborate oral traditions, reiterate the point that the introduction of the Coronavirus Alleviation Program (CAP) provided relief to small and medium-sized enterprises (SMEs) and vulnerable households, and additionally, the Bank of Ghana reduced the policy rate to stimulate economic activities in the country (Awuku, 2022, personal interview). These interventions were part of a broader strategy seen across many countries, where governments adopted fiscal and monetary policies to cushion their economies against the shock of the pandemic (WB, 2021). However, the effectiveness of these measures in Ghana was tempered by structural challenges, including the large informal sector, which comprises about 80% of the workforce. Many informal workers, such as traders and artisans, were left without adequate social protection during the lockdowns, highlighting the limitations of the government's interventions in reaching the most vulnerable populations. Kojo Bonsu Kwamena, originally from Kumasi, recounted his efforts to support Ghana through tech-driven solutions (Kwamena, 2021, personal interview). He collaborated with other Diasporans to develop a contact-tracing app for use in Ghana. He discussed how the pandemic strengthened his connection to his homeland, leading to increased efforts to give back and contribute to public health initiatives (Agyeman, 2021, personal interview).

It is worth the emphasis that in the early stages of the COVID-19 pandemic, leaders worldwide were confronted with the dual challenge of protecting public health while managing the economic fallout of the crisis. In this context, Ghana's President, Nana Akufo-Addo's poignant statement, "*We can bring back the economy, but what we do not know how to do is to bring back lives*" (Akufo-Addo, 2020; Boateng, 2020; Amankwa, 2020; Nyarko, 2020) is significant to consider. This statement encapsulates a profound ethical and pragmatic dilemma faced by governments in responding to the pandemic. The President's statement reflects prioritization of

public health over economic considerations. A stance that aligns with the precautionary principle often invoked in public health crises. The precautionary principle argues that in situations of uncertainty, especially where lives are at stake, it is prudent to err on the side of caution to avoid potentially catastrophic outcomes (Opoku, 2021, personal interview; Goldstein, 2001). Prioritizing life over economic stability reflects a moral imperative rooted in deontological ethics, emphasizing the duty to protect human life as paramount in the face of immediate threats such as COVID-19.

While acknowledging severe economic costs, the government prioritized health on the grounds that economies can recover, but lost lives cannot. Akufo-Addo's (2020) stance highlights ethical and policy commitments to human welfare and the protection of life and health as fundamental rights in governance (United Nations, 1948). Moreover, this stance may be interpreted as an acknowledgement of the interconnectedness of health and economic stability. While the economy can be revitalized, a healthy population is essential for sustainable economic growth. The long-term economic recovery of Ghana, and indeed any country, hinges on the health and well-being of its citizens. Despite its moral appeal, Akufo-Addo's (2020) position has been critiqued for overlooking how strict lockdowns can indirectly harm health in lower-income contexts by deepening poverty, food insecurity, and limiting access to healthcare, potentially increasing mortality and morbidity (Gershman and Morduch, 2020).

In Ghana, the economic impact of the pandemic exacerbated pre-existing inequalities and created new vulnerabilities, particularly among informal workers and small business owners who were disproportionately affected by the lockdown measures (Gershman and Morduch, 2020). The pandemic intensified debates over balancing lives and livelihoods while reshaping global health priorities, accelerating digital health adoption, strengthening attention to public health infrastructure, and emphasizing pandemic preparedness and a One Health approach. It also highlighted diaspora engagement, exemplified by Kwame Mensah, a Ghanaian nurse in the U.S., who helped train nurses in Ghana through virtual COVID-19 initiatives (Mensah, K., 2021, personal interview). He also contributed financially to a donation drive for PPEs to Ghana's frontline workers. Mensah (2021) also emphasized the importance of Diasporan involvement in helping Ghana tackle the pandemic. It is important to mention that future efforts to prevent and respond to pandemics must take into account the complex interactions between these domains.

The Diaspora and Africa's Perspectives and Responses

Joseph Harris asserts that the African diaspora encompasses both voluntary and involuntary global dispersal and the formation of shared cultural identities beyond the continent (Harris, 1993). Recent globalization, mobility, and pandemics have renewed scholarly interest in African diasporic communities and their influence on the continent. COVID-19 highlighted the deep connections between Ghana and its Black Diaspora, whose economic, healthcare, and

cultural support proved vital (Rotmi *et al.*, 2016). The diaspora, comprising both recent migrants and multi-generational descendants of African origin across Europe, North America, the Caribbean, and parts of Asia (Taslakian *et al.*, 2022), played a significant role in Ghana's pandemic response (Opoku, 2021, personal interview). Differences in culture, socio-economic status, and proximity to Africa shaped varied responses to COVID-19. Aspinall captures this explicitly when he explains that minority ethnic communities, including Black Africans, were disproportionately affected by COVID-19 in the United Kingdom, mirroring a similar pattern in the United States (Aspinall, 2021). Diasporan perspectives were shaped by conditions in host countries, where severe health and economic disruptions in the US and UK heightened vulnerabilities, particularly for Africans and Afro-Caribbeans overrepresented in high-risk essential occupations (Opoku, 2021, personal interview).

The African diaspora confronted challenges of misinformation and mistrust toward public health authorities, with social media simultaneously aiding information sharing and spreading myths, thereby complicating responses to COVID-19 (Opoku, 2021, personal interview). Despite challenges, the pandemic underscored strong diaspora solidarity, as communities mobilized remittances, supported health initiatives, and led awareness campaigns, playing a vital role in cushioning Africa's economic and social impacts of COVID-19. Collaborating this, Patrick Kuma-Aboagye (2021, personal interview) intimates that the Ghanaian diaspora's response to the COVID-19 pandemic was multifaceted, with contributions ranging from financial support to advocacy and policy influence. During COVID-19, diaspora remittances, advocacy, and professional expertise were central to Ghana's response, supporting households, healthcare, and vaccine equity, while revealing coordination and sustainability challenges that highlight the need for more structured diaspora engagement.

A COMPARATIVE ANALYSIS OF THE AFRICAN STRATEGY TO THE COVID-19 CHALLENGE

Loewenson *et al.* (2021) assert that the COVID-19 pandemic produced uneven global impacts and responses, with Africa adopting diverse strategies shaped by its socio-economic and political contexts. Compared with other regions, Appiah and Osei (2020), Ampofo (2020), Mensah (2021) and Nyarko (2020), all hold the view that African countries emphasized early containment through lockdowns, border closures, and quarantine measures, informed by external experiences and constrained by public health capacity, governance, and international cooperation. Countries such as South Africa, Rwanda, and Ghana imposed early lockdowns based on prior epidemic experience, helping to delay COVID-19 transmission and allowing time to prepare healthcare systems. Africa's COVID-19 response emphasized public health messaging and community engagement, with governments partnering with local leaders and organizations to promote prevention and surveillance. Early lockdowns and community-based measures in countries such as South Africa, Rwanda, and Ghana helped delay COVID-19 transmission and improve compliance, but weak healthcare

systems, existing disease burdens, and socio-economic constraints limited their overall effectiveness. Anthony Nsiah-Asare (2021, personal interview), intimates that many African countries struggled with inadequate testing capacity, which hindered efforts to track and control the spread of the virus. During COVID-19, testing and critical care in Africa were concentrated in urban areas, leaving rural populations underserved, while delayed vaccine access and reliance on COVAX exposed inequalities in global health governance. Studies have shown that despite lower reported case numbers compared to other regions, Africa faced significant under-testing and under-reporting, masking the true burden of the pandemic (LGH, 2020; Devermont, 2020).

CONCLUSION

Limitations

The study situates Africa and the Black Diaspora within the global intellectual history of pandemics, using Ghana to illustrate how historical memory, governance, and social ethics shaped COVID-19 responses, revealing pandemics as political, moral, and intellectual phenomena beyond biomedical events (Amevor, 2025). By centring African perspectives, the study fills a key gap in pandemic scholarship, while recognizing limitations stemming from its reliance on qualitative documentary and media sources with uneven coverage across African states (Markhof *et al.*, 2025). Although Ghana is the main case study, Africa's diversity limits generalization, and pandemic conditions restricted interviews and deeper ethnographic research (Matlala, 2025). Despite its limitations, the study provides a strong interpretive framework that deepens scholarly understanding of pandemics in Africa.

Theoretical Implications

The study advances global intellectual history and pandemic theory by showing that African responses to COVID-19 were shaped by historically embedded epistemologies, including communal ethics, colonial medical legacies, and prior epidemic experiences (Matlala, 2025). Secondly, the article reframes pandemics as intellectual and social phenomena, integrating political discourse, moral reasoning, and historical consciousness into pandemic analysis (Kelly, 2006; Coccia, 2023b). The study challenges deficit-based narratives by emphasizing Mukolwe *et al.* (2025) and Montcho *et al.* (2025), who note that African agency, adaptive governance, and community-driven responses countering portrayals of Africa solely as vulnerable. The study advances a transnational framework that positions the Black Diaspora as a key actor in African pandemic responses through advocacy, remittances, and knowledge exchange, contributing to a more inclusive global history of pandemics.

Policy Implications

The findings yield important policy lessons for Africa and other developing regions confronting future health crises. Following recent studies such as Flaxman *et al.* (2020), the study thesis states that good governance and public trust are critical to effective pandemic response; transparent communication and ethical framing enhance compliance and social cohesion. Yet, Health expenditures and system

strengthening, including investments in primary healthcare, disease surveillance, and workforce capacity, remain essential (Coccia, 2022b; Coccia and Benati, 2024). Again, preparedness beyond vaccination is necessary; effective contact tracing, non-pharmaceutical interventions, and environmental health measures significantly reduce infection and mortality (Benati and Coccia, 2022). Also of importance is regional cooperation, particularly through the African Union and Africa Centres for Disease Control and Prevention (CDC), enhances coordinated responses and resource sharing (Petersen, 2025). Furthermore, economic resilience and social protection, especially for informal-sector workers, are vital to mitigating the socio-economic effects of pandemics (Otegunrin, 2025).

Ideas for Future Research

This study opens several avenues for further inquiry:

- Comparative historical analyses of pandemic responses across African sub-regions.
- Ethnographic studies on community perceptions of risk, authority, and compliance.
- Longitudinal research on state–citizen relations and governance norms after COVID-19.

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Conflict of Interest

The author declares that there is no conflict of interest regarding the publication of this manuscript. In addition, the ethical issues, including plagiarism, informed consent, misconduct, data fabrication and/ or falsification, double publication and/ or submission, and redundancy, have been completely observed by the authors.

Life Science Reporting

No life science threat was practised in this research.

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LIST OF ORAL INTERVIEWS

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