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The Journal publishes articles from broad fields of study with at least one of the following criteria:

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- Already existing data and with a unique or advanced theory.
- Practical cases in one of the following analytical dimensions:
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- Narrate and analyze undocumented events or practices with suitable academic rigour.
- Unless it is especially relevant to the present or is a critical account of a missing piece of history, biographic and/or autographic narratives are not published in this Journal. The Journal would particularly like to publish critical analyses of Africa's social, cultural and political factors that influence peace and state building in Africa. It ultimately aims to gather cross-cutting themes that would inform policymakers, civil society, and academicians, and also advance the promotion of effective interventions across Africa. Unless explicitly specified in the call for papers of a specific edition, articles within this scope are considered for review.

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## Editor's Note

COVID-19 began as a shared global challenge in need of international action and solidarity. In some areas, Africa's response to the pandemic has been hampered by failure to build resilient social systems, agile institutions, and inclusive economic growth. Like all other industries and sectors over the last two years, Africa's academics are contributing to interpreting the current crisis and contemplating the world that is likely to emerge from this era. This requires disruptive and innovative approaches that are bound to challenge the classic discourses while offering the new models emerging. The papers in this volume focus on rethinking peace and security in the context of the COVID-19 pandemic. We, at the Institute for Peace and Security Studies, hope that this issue is of value to you and provokes liberating questions.

My sincere gratitude to the authors that contributed to this volume: Abdou Rahim Lema, Lukmon Akintola, Anene Chidi Pensive, Nzube Aguchukwu Chukwuma, Mutsa Murenje, Shauna Kimone Porter, Sharkdam Wapmuk, Nufaisa Garba Ahmed, and Brivery Siamabele.

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# Pandemics and Cross-Border Trade

**Brivory Siamabele**

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## Abstract

This paper examines the impacts of the Coronavirus (COVID-19) on cross-border trade and its implications on trade within and amongst African countries. Intermittent outbreaks of infectious diseases have had profound and lasting effects on societies throughout history. Using desk research, the paper argues that the COVID-19 pandemic presents unprecedented public health, social and economic challenges, including affecting international trade. Measures to curb the spread of the disease shut down large swathes of the global economy leading to dramatic negative supply and demand shocks. This study argues that pandemics are inherently uncertain, necessitating flexible policies in responding to outbreaks as they develop.

## Keywords

Contextualize, COVID-19, cross-border trade, globalization, pandemic, public health, socio-political dynamics

## Introduction

Pandemic outbreaks have been closely examined through the lens of humanities in the realm of history, including the history of medicine (De Witte, 2014). There have been pandemic outbreaks that the world has faced, including the Black Death (a plague outbreak from the fourteenth century), the Spanish Flu of 1918 and the more recent outbreaks of the Severe Acute Respiratory Syndrome (SARS), Ebola, and Zika. In the era of modern humanities, however, little attention has been given to review how the different pandemics have affected the individual and group psychology of affected societies (CDC, 1918).

There have also been many pandemics of lesser magnitude throughout history. Potter (2001) identifies about ten pandemics in the past 300 years, arguing that pandemics follow a recurrent, although not a regular periodic, pattern, so we should not rule out the possibility of new medical disasters of this type in the future. According to Kilbourne (2005), the world was hit by three pandemics in the 20<sup>th</sup> century: Spanish influenza in 1918 (CDC, 1918), Asian influenza in 1957 and Hong Kong influenza in 1968. This study argues that COVID-19 is likely to affect

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cross-border trade more than any past pandemic because it occurred when the world was more integrated than ever. COVID-19 has happened at a time when the world has been globalized.

Studies like that of Brainerd and Siegler (2003) and Young (2004) that investigated the macro-economic impact of pandemics and other major diseases such as SARS and HIV/AIDS have attempted to quantify the consequences in terms of lost output, growth and consumption. These studies concluded that pandemics reduce national outputs but increase consumption levels. However, there is little consensus. The results depend crucially on the models used and on the availability of data. Although literature on the Black Death is substantial, researchers have not reached firm conclusions concerning its long-run effects (Bell & Lewis, 2004).

Nevertheless, a 2019 joint report by the World Health Organization (WHO) and the World Bank estimated the impact of such a pandemic upwards, bringing the total cost to between 2.2%-4.8% of global GDP (US\$3 trillion). The report further noted that in such an event, South Asia's GDP could potentially fall by 2% (US\$53 billion) and Sub-Saharan Africa's GDP by 1.7% (US\$28 billion) (WHO, 2019). The International Monetary Fund (IMF) found that vulnerable populations, particularly the poor, suffered disproportionately from an outbreak. They may have less access to healthcare and lower savings to protect them against financial catastrophe (IMF, 2020). This was aggravated by the lack of investments in infrastructure development in most developing countries (OECD, 2020; Congressional Research Service, 2020).

While at the regional level, a World Bank report estimated that the Ebola epidemic in Guinea, Liberia, and Sierra Leone, derailed many of the previous years' economic gains in these countries, which, until then, were among the fastest-growing economies in the world (World Bank, 2016). A WHO report further explained that the outbreak caused a substantial loss of growth in the private sector, posed threats to food security due to a decline in agricultural production and burdened cross-border trade with restrictions on movement, goods, and services (World Bank, 2019).

As the Coronavirus emerged in China and spread globally, authorities acted to limit its spread. Experience with similar diseases revealed that while the human costs were significant, the bulk of the economic costs were due to the preventive behaviour of individuals and the transmission control policies of governments (Brahmbhatt and Dutta, 2008).

In Africa, COVID-19 has disproportionately disrupted the livelihoods of poor households and small and informal businesses. According to the initial analysis on the economic impact of COVID-19 in Africa, the average GDP growth of the continent in 2020 could be cut by 3–8 percentage points (Jayaram and Leke, 2020), the highest being the worst case and resulting in a negative growth rate of -3.9% (Jayaram *et al.*, 2020). Any disruptions on the livelihoods of the people in Africa directly disrupt the opportunities of exports and imports, which now reduces trade within and amongst African countries.

The United Nations Economic Commission for Africa (UNECA) predicted that the continent would experience a 1.4% GDP decline with a monetary value estimated to be US\$29 billion (i.e.,



from US\$66 billion in 2019 to US\$37 billion in 2020) (UNECA, 2020). At a national level, it was estimated that COVID-19 would shave 2.9% off this fiscal year's economic growth in Ethiopia (UNICEF Ethiopia, 2020). Building on previous studies, this paper focuses on evaluating the impact of the pandemic on cross-border trade and its implications within and across borders.

## Methodology

This study used data from secondary sources to analyze the Impact of COVID-19 on cross-border trade in Africa. The analysis was conducted using the information found in reports, documents, published and unpublished materials obtained from reputable sources such as the World Health Organization, World Trade Organization (WTO) and UNCTAD documents. These sources were substantive as they provided current data to analyze how COVID-19 had impacted trade within and amongst African countries.

## Past pandemics and trade

Historically, pandemics caused significant economic and trade challenges globally, due to the interconnected nature of our world. The first pandemic of the eighteenth century began in the spring of 1729 in Russia, spreading across Europe during the ensuing six months and around the globe over the next three years (Pyle, 1986; Hirsh, 1983; Patterson, 1987; and Finkler, 1899). The outbreak occurred in multiple waves with more recent pandemics with higher associated morbidity and mortality at later stages (Beveridge, 1991; Patterson, 1987). The second pandemic of that century originated in China in 1781 (Pyle, 1986; Finkler, 1899). It spread through Russia and Europe for eight months, with an exceptionally high attack rate among young adults (Pyle & Patterson, 1984).

The major pandemic of the nineteenth century began in the winter of 1830 in China (Potter, 2001). This pandemic was reported to be of similar severity to the 1918 Spanish flu pandemic. It spread across Southeast Asia, Russia, Europe, and North America by 1831 (Pyle, 1986; Beveridge, 1991; Patterson, 1987). Despite a high illness attack rate, associated mortality was low (Potter, 2012). In the winter of 1889, another pandemic emerged in Russia, spreading by rail and sea across Europe and North America (Pyle, 1984; Patterson, 1987). With an estimated case fatality rate in the range of 0.1%–0.28%, the outbreak killed about one million people globally (Valeron, 1889). This pandemic spread faster than previous ones and may have provided the first indication of the accelerated spread of emergent diseases due to progress in transportation technology.

In response to the above pandemic, efforts to control outbreaks relied on non-pharmaceutical interventions (NPIs), such as quarantines, school closures, banning public gatherings, and infection prevention practices like cough and sneeze etiquette and use of face masks (Markel *et al.*, 2006). Interventions were of variable effectiveness. For example, the gauze face masks would have effectively prevented bacterial infection but were too porous to stop viral penetration, and many people resisted their use regardless. Governments issued directives on the dangers of influenza, but these were often poorly understood or ignored (USDHHS, The Great Pandemic, 1919). The Severe Acute Respiratory Syndrome (SARS) was the first outbreak in the twenty-first

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century that managed to get public attention. Caused by the SARS Coronavirus (SARS-CoV), it started in China. It affected fewer than 10,000 individuals, mainly in China, Hong Kong, and other countries, including 251 cases in Canada (Toronto) (Damir, 2019).

Africa recently experienced its pandemic in 2014, where the West Africa region was confronted with the worst Ebola Virus Disease (EVD) outbreak ever observed in Africa, causing tragic loss of lives, impacting national economies and adversely impacting agriculture, food and nutrition security in the region (WHO, 2015). Governments, institutions and infrastructures struggled to cope with the enormous challenges posed by the epidemic while the way of life of affected populations hung in the balance (FAO-UN, 2016).

The EVD outbreak in Guinea, Liberia and Sierra Leone was unprecedented and caused major public health and socio-economic crises as of 2014. It had multiple and long-lasting repercussions on rural societies throughout the West African region (FAO-UN, 2016). The Ebola virus prevented West Africa from trading within and amongst each other for fear of spreading the virus. This, however, had great impacts on supply and demand due to the freeze on movement of goods and products across the borders. In addition to the tragic human death toll, the epidemic severely affected agricultural market chains in the three countries. This was aggravated, indeed, by the disease itself and its dramatic public health impact. The measures implemented to limit its propagation (such as movement restrictions on collective transport, closure of weekly markets and borders) had a tremendous social and economic impact on the local communities that depended on agriculture as their primary source of livelihood (FAO-UN, 2016).

The Ebola pandemic affected the proper functioning of market chains and the flow of agricultural products, and key factors influencing food and nutrition security. In the globalization era, countries were increasingly dependent on markets and their proper functioning for their food and nutrition security, as revealed by food security studies conducted in the three countries (WFP-CILSS-FEWS NET, 2010; WFP-Guinea, 2010; WFP-Liberia, 2010).

The Ebola-related control measures of border closure between affected countries also disrupted regional trade dynamics in West Africa and even affected the global trade ties as most countries could not accept or allow any movements into and out of these affected countries. According to the FAO rapid assessment in Sierra Leone, rice producers and traders in Kambia and Port Loko districts faced physical constraints to reaching markets in Guinea and Freetown due to movement restrictions and market closures. This resulted in the loss of contracts for producers and loss of income, and reduced activity for most agribusinesses (FAO-Sierra Leone, 2014a).

The year 2014 marked the first time that flights per day exceeded an annual average of 100,000, while 2013 was the first time when annual passengers exceeded 3 billion (Garfors, 2014). Meanwhile, global population growth continues. When the 1918 pandemic occurred, the global population was around 1.8 billion (Madhav *et al.*, 2013); as of July 2016, the World Population Clock estimates a global population of about 7.4 billion (World Population Clock Current World Population, 2016). If today's pandemic were to kill the same proportion as in 1918, this would equal between 74 and 370 million people. Nevertheless, population growth, human mobility,

and greater proximity to animal reservoirs increase both the risk of pandemic emergence and the speed with which pandemics can spread across the globe. Between 1700 and 1889, the average inter-pandemic period ranged from 50 to 60 years; since 1889, this period has shortened to 10 to 40 years (Potter, 2001). While a pandemic one hundred years ago would take weeks or months to spread globally, an infection today is spreading to every continent, country, community and household in days, if not hours. This increased risk can only be addressed by combining local, national, and international efforts to improve mitigation and containment of future pandemics.

## The Coronavirus and trade

Trade is typically more volatile than output and tends to fall particularly sharply in times of crisis (Freund, 2009; Bussière *et al.*, 2013; Bems *et al.*, 2010; Kose and Terrones, 2015). Generally, investment, which is more cyclical and more trade-intensive than other categories of expenditure, has declined worldwide as firms face financing challenges and delay in expansion. Travel restrictions and concerns about COVID-19 led to a precipitous fall in tourism—a sector that in recent years accounted for about 6.5% of global exports of goods and services—with sharp declines in economies with the most severe outbreaks (Ahn *et al.*, 2011; Chor and Manova, 2012). Tourism is an important income-generator in Africa. The World Travel and Tourism Council (WTTC) has demonstrated that over a third of all direct tourism GDP in 2018 was attributed to wildlife. This is important for many African countries such as Botswana, Kenya and South Africa and many of the continent's least developed countries (LDCs) such as Madagascar, Rwanda, Tanzania and Uganda, where the wildlife tourism sector is lucrative for economies and livelihoods.

Many studies have found that population health, as measured by life expectancy, infant and child mortality and maternal mortality is positively related to economic welfare and growth (Pritchett and Summers, 1996; Bloom and Sachs, 1998; Bhargava *et al.*, 2001; Cuddington *et al.*, 1994; Cuddington and Hancock, 1994; Robalino *et al.*, 2002a; Robalino *et al.*, 2002b; WHO Commission on Macroeconomics and Health, 2001; Haacker, 2004).

There are many channels through which an infectious disease outbreak influences the economy. Direct and indirect economic costs of illness were often the subject of health economics studies on the burden of disease (WHO, 2009). The conventional approach uses information on deaths (mortality) and illness that prevents work (morbidity) to estimate the loss of future income due to death and disability. Losses of time and income by careers and direct expenditure on medical care and support services are added to estimate the economic costs associated with the disease (WHO, 2004). This conventional approach negatively affects trade by underestimating the true economic costs of infectious diseases of epidemic proportions that are highly transmissible and for which there is no vaccine (McKibbin and Fernado, 2020).

The experience from the previous disease outbreaks provides valuable information on how to think and imagine the implications of COVID-19 on trade. COVID-19 affected households, businesses and governments in labour supply decisions, labour efficiency, household incomes, business costs and foreign investments (Mirzoev and Sedaghat, 2020). Haacker (2004) states that pandemics lead to increased public expenditure on health care and support for disabled and

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orphaned children. Conventionally, this has implications on the productive sectors of countries, especially the developing countries. Largely, this affects but also shifts the investments from the productive sectors to health and public health regulations in the quest to reduce the spread of the diseases. Labour implications affect the economic productivity capacities of developing countries, directly reducing the levels of exports and imports.

Unlike other pandemics, the influenza virus was by far more contagious than HIV, for example, and the onset of the epidemic was sudden and unexpected. The COVID-19 virus was also very contagious, sudden and unexpected.

Nevertheless, the fear factor was influential in the world's response to SARS—a coronavirus not previously detected in humans (Shannon and Willoughby, 2004; Peiris *et al.*, 2004). It was also reflected in the responses to COVID-19. For example, when COVID-19 was discovered, all cities in China were closed, and travel restrictions were enforced by countries on people entering from infected countries. In most cases, the most infected countries were the industrial countries with whom developing countries trade. That means trade, to a larger extent, was negatively affected as goods and services could no longer be freely moved between and amongst countries. This affected the living standards of the population at large, especially those markets that depended most on importations (OECD, 2020). The fear of an unknown deadly virus was similar in its psychological effects to the reaction to biological and other terrorist threats causing high levels of stress and anxiety, often with long-term consequences (Hyams *et al.*, 2002). Many people would feel at risk at the onset of a pandemic, even if their actual risk of dying of the disease was low.

Furthermore, studies conducted in 2003 on the effects of the SARS epidemic on the macroeconomy found significant negative effects on trade through large reductions in consumption of various goods and services, increase in business operating costs, and re-evaluation of country risks reflected in increased risk premiums. Such effects had negatively impacted the production levels and purchasing power of the people. COVID-19 had its own peculiarities with the imposition of tougher restrictions in movements beyond social distancing to closures of cross-borders (Chou *et al.*, 2004; Sui and Wong, 2004).

Also, shocks to other economies during the SARS pandemic were transmitted according to the degree of the countries' exposure or susceptibility to the disease. Nevertheless, the impacts were marginal for the developing countries; despite a relatively small number of cases and deaths, the global costs were significant and not limited to the directly affected countries (Lee and McKibbin, 2003). This is the case with the COVID-19 pandemic, where developing countries experienced a relatively smaller number of infected people, yet the impacts on trade were enormous and getting worse day by day due to travel and transportation restrictions. Other studies of SARS include (Chou *et al.*, 2004) for Taiwan, (Hai *et al.*, 2004) for China and (Sui and Wong, 2004) for Hong Kong.

Bloom *et al.* (2005) used the Oxford Economic Forecasting Model to estimate the potential economic impact of a pandemic resulting from the mutation of the avian influenza strain. They indicated how the pandemic had the possibility of contracting cross-border trade and further assumed that it was a mild pandemic with a 20% attack rate, a 0.5% case-fatality rate, and a

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consumption shock of 3%. Scenarios include two-quarters of demand contraction only in Asia (combined effect of 2.6% Asian GDP or US\$113.2 billion); a longer-term shock with a longer outbreak; and larger shock to consumption and export yields (a loss of 6.5% of GDP or US\$282.7 billion). With COVID-19, it is rather feared that the trade implications could be beyond what Bloom and others indicated because this pandemic has a long-term shock as it had put the world on a standstill in all aspects of the world economy. Global GDP, according to Bloom and colleagues, during the SARS was reduced by 0.6% and global trade of goods and services contracted by \$2.5 trillion (14%). Nevertheless, open and less stable economies were more vulnerable to international shocks, as is the case in the COVID-19 pandemic period.

McKibbin and Fernando (2020), learning from the approach used by Lee & McKibbin (2003) and McKibbin & Sidorenko (2006), converted the different assumptions about mortality rates and morbidity rates in the country where the disease outbreak occurs (the epicentre country). Given the epidemiological assumptions based on previous experience of pandemics, they created filters that converted the economic shocks to reduced labour supply in each country (mortality and morbidity); the rising cost of doing business in each sector, including disruption of production networks in each country; consumption reduction due to shifts in consumer preferences over each good from each country (in addition to changes generated by the model based on the change in income and prices); rise in equity risk premia on companies in each sector in each country (based on exposure to the disease); and increases in country risk premium based on exposure to the disease and vulnerabilities to changing macroeconomic conditions (OECD, 2020). COVID-19 is, however, feared to have worse implications on trade than the past pandemics as many countries have experienced two or more lockdowns. Despite measures put in place to curb the economic impacts, there still is a fear that the impacts are enormous, especially for agriculture-dependent countries, as is the case with most African countries (WHO, 2020).

McKibbin and Wilcoxon applied a global intertemporal general equilibrium model with heterogeneous agents called the G-Cubed Multi-Country Model. This model is a hybrid of the Dynamic Stochastic General Equilibrium (DSGE) Model and Computable General Equilibrium (CGE) Model developed by McKibbin and Wilcoxon (1999, 2013). The hybrid model helps in seeing the implications of the pandemic on trade within and amongst countries.

The COVID-19 pandemic has been highly disruptive to development financing in Africa, regardless of the source of revenue. Oil prices had a historic collapse from US\$61.5 in December 2019 to US\$23.2 in March 2020. This is a major blow to a continent whose oil rents represent 4.5% of GDP (OECD/ATAF/AUC, 2019). The contraction of world trade has affected the productive apparatus of several sectors across the continent. For example, African industries import over 50% of their industrial machinery and manufacturing and transport equipment from outside the continent. The most important suppliers are Europe (35%), China (16%) and the rest of Asia, including India (14%). As such, COVID-19-related disruptions in global supply chains, especially from China and Europe, have led to a decrease in the availability of final and intermediate goods imported to Africa. In the long run, lower value-added sectors such as agribusiness, flowers, or

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garments would suffer the most from shortages in supply, and possible relocating of production activities closer to final markets would be necessary (ECA, 2020).

Overall, the impacts of COVID-19 vary across African countries, both within and across sectors. The fall in global demand for exports and a slump in prices of major commodities, including fuels, are the main concerns for Africa. There has also been a fall in Foreign Direct Investment (FDI), which is closely linked to the extractive sector and hence the commodity price cycle (UNCTA-World Investment Report, 2020). The decline in crude oil prices by up to 60% has put significant strains on the revenue of the net oil exporters, particularly those whose revenues are highly determined by crude oil sales. Reports by UNCTAD (2020) suggest a -11.4% decline in Nigeria's revenue in 2020 with relatively lower revenue falls for the other key exporters of fuels in the region such as Algeria (-2.5%), Angola (-3.8%), Gabon (-2.4%) and Congo (-2.3%). However, the final impact will depend on how the respective countries will take advantage of their respective key markets as frontier closures are lifted with productivity resumed in the world. Overall, fuel exports are estimated to fall by -7.7%, with a significant drop in GDP of about -3.3% in Congo and Mozambique (UNCTAD, 2020).

Generally, a protracted global recession causing low demand for their exports with resultant revenue losses had significant consequences not just for agriculture but also other sectors of their economies, with poverty and food insecurity rising not only currently but also expected to worsen in 2021 (Akiwumi and Valensisi, 2020). Recent food security estimates suggest that 73 million people in Africa are acutely food insecure. This alarming situation is being exacerbated by the current COVID-19 crisis through its direct impacts on trade and logistics as well as on production and value chains. Administrative restrictions imposed by governments such as lockdowns, travel restrictions and physical distancing measures have also contributed to worsening the situation. The burden of movement restrictions and lockdowns is being felt particularly strongly by low-income households and those working in the informal economy due to their loss of livelihoods and inability to access markets (UNCTAD, 2020). Additionally, despite fuel prices being favourable to net importers of fuels, the recession in LDCs and SIDS economies may also lead to reduced fuel imports as production in other sectors remains depressed. For example, countries like Burundi (-26.6%), Cabo Verde (-8.5%), Comoros (-30%) and Malawi (-15%) are all expected to import less fuel by the indicated amounts over the year. A potentially deep recession in the global economy will result in significant losses in Africa, with a fall in GDP of -1.4%. Most countries are expected to suffer a recession as a result of the decline in world GDP and fuel prices, but the impact is expected to be disproportionately higher amongst net food exporters (UNCTAD, 2020).

This paper, however, argues that implementing measures in response to COVID-19 must take into consideration the local economic and social realities of different communities. In other words, public health measures taken to reduce the spread of the virus must go beyond the one-size-fits-all approach that sees the world through a Western lens to context-specific understandings of diseases. Africa, for example, is not Europe, even in the context of so-called globalization. The perspectives and responses of the local population are important. The world is now moving into

online shopping, but it is unfitting to say that Africans should engage in internet shopping because that would be denying the reality of poverty and lack of access to information technology in this part of the world.

## **Institutional analysis on trade**

Africa has key institutions whose aim has been to expand and facilitate trade within Africa, but COVID-19 has contracted everything in this regard, hence, exposing countries to a lot of trade challenges simply beyond financial assistance. The continent as a whole has seen the birth of the African Continental Free Trade Area with the aim of facilitating the expansion of Intra-African Trade. One of the objectives of the AFCTA is to create a single market for goods, services, facilitated by the movement of persons in order to deepen the economic integration of the African continent and in accordance with the Pan-African vision of “An integrated, prosperous and peaceful Africa” enshrined in Agenda 2063 (Agreement Establishing the AFCTA, 2018). In the face of COVID-19, this objective is being challenged as people are not free to move or transport their goods and services due to massive restrictions meant to reduce the spread of the virus.

Furthermore, institutions such as the African Export-Import Bank (Afreximbank) regard intra-African trade as trade in goods and services between or among African countries and the flow of goods and services between Africa and Africans in the Diaspora. The Intra-African Trade Strategy, as conceived and conceptualized by the Afreximbank, is viewed through three main pillars, namely, Create, Connect and Deliver, with an ancillary pillar known as measure (Africa Export-Import Bank, 2017).

Afreximbank, on the first pillar of creating, aims at building the capacity for the expansion of production and processing capabilities, with a focus on agricultural production, agro-processing, manufacturing and services (Afreximbank, 2017). This pillar has been heavily affected by COVID-19 in that the agricultural sector and other productive sectors are either non-operational or operational to a little extent. This paper also argues that the majority of agricultural products come from small-scale farmers continentally who are also affected by COVID-19. The bank, through this pillar, is supposed to facilitate capacity for expansion of tradable goods and services that can enter the trade. Nevertheless, less or no production in the productive sectors entails that trade within and even with the outside world is affected.

Despite the bank facilitating the environment for the flow of goods through the creation of robust in-country and intra-regional supply chains in Africa with the pillar of Connect, the productive sectors are not meeting the goals and aims of trade. This means there are no institutions that the bank can support, so they would be able to connect producers and buyers along the intra-African value chain (UNCTADStats, 2017).

With regard to the last pillar of delivering, the bank aims to provide efficient and cost-effective distribution channels for the delivery of goods and services to buyers within the continent and support the emergence of facilitative infrastructure including transportation and logistics, as

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well as introduce an intra-African trade payment platform. In view of this aim, this paper argues that the bank must expand investments in the digital trade that could assist the producers and buyers in their small productive capacities. This will help the continent to be viable in intra-trade and be able to enhance people's livelihoods. The Bank could still expand the digital trade with the already existing infrastructure, including transportation and logistics and also introduce an intra-African trade payment platform (UNCTADStats, 2017).

However, the continent accounts for less than 3% of world trade (UNCTADStats, 2018). This is because the continent is mostly endowed with commodities and natural resources continue to dominate Africa's export basket, and the continent's participation in the global value chain has been minimal. Nevertheless, the continent has improved in the value chain with increased productions from Nigeria, South Africa, Kenya and Egypt, and these countries have a lot of potential to support the intra-African Trade (UNCTAD, 2019). On the contrary, with intra-African trade, Africa continues to trail other regions which have drawn on vibrant cross-border trade to sustain growth, economic development and integration into the global economy. At about 15%, Africa compared unfavourably to Europe (68%), North America (37%), and Latin America (20%) (Afreximbank, 2018).

The implementation of the African Continental Free Trade Area (AfCFTA) Agreement will make the African continental market the world's largest free trade area. As its implementation is ongoing, global markets and countries in Africa, Asia, Europe and the Americas are being affected by the new Coronavirus (COVID-19). This is having a negative multiplier effect on almost all aspects of human engagements, including trade, finance, travel, employment and contracts. COVID-19 restrictions are constraining the benefits of the AfCFTA, whose mandate is to incorporate all 55 African countries with a population of 1.2 billion and a combined GDP of \$2.5 billion (Adetuyi, 2020). The AfCFTA is mandated to facilitate the removal of tariffs and trade barriers to free up trade and deepen intra-African trade and regional integration, which is an important tenet of the AfCFTA. Also, the AfCFTA, once in effect, is likely to lead the shift in technology frontier and improvement in productivity spillovers within African countries that will result from trade creation. Technology enhancement is important in the era of the pandemic as it will eliminate the physical trade in cross-borders.

According to UNCTAD (2019), Africa's development in terms of merchandise exports is still confronted with multiple challenges. Amongst these challenges, the continent has continuously been faced with high costs related to poor quality of infrastructure and logistics, low processing capacity and the overwhelming dominance of primary commodities and natural resources in Africa's exports, exposing the region to recurrent adverse commodity terms-of-trade shocks. Compounded with these challenges, Africa is now faced with a global pandemic of COVID-19 with a few coping strategies at its disposal. COVID-19 has affected the world at large, but in Africa, where there are a lot of trade bottlenecks already, intra-trade is left challenged due to restrictions in people's movements, amongst other reasons, and this is reducing the cross-border trade.



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The global economy has almost been brought to its knees from the severe, wide and deep impacts of the COVID-19 pandemic, placing all past development gains at risk. The COVID-19 pandemic has disrupted businesses, jobs and household livelihoods, resulting in increased poverty—with the poorest and vulnerable suffering the most. In addition, the resultant illness has overwhelmed health systems and social safety net responses, with the burden being proportionately higher for Africa's weaker economies. The total impact is yet to be accurately determined through more in-depth analyses (United Nations, 2020).

Despite these challenges, Africa's total merchandise imports posted a strong recovery growing by an estimated 5.4% in 2017 to reach US\$502.28 billion after a contraction of 10.9% in 2016. However, it remained below US\$534.97 billion in 2015 (Afreximbank, 2018). The resurgence of growth in Africa's imports was driven largely by a recovery in foreign reserves, which now has been highly affected by COVID-19 and compounded with high international debts. Most Africa countries have borrowed beyond their recovery capacities during COVID-19. This largely has implications as the purposes of the borrowing have not been clearly stipulated. Even if they had been, the money has not been fully invested in what is claimed. This is because Africans largely have not understood their socio-political and economic dynamics. After all, if they had, they would not be taking the homogeneous perspectives of combating the virus without reflecting on context specificities (OECD, 2020).

Contextualizing the policies meant that reducing the spread of the virus requires development institutions to understand what regulations to put in the context of Africa without copying and pasting the western practice. The western ways of reducing the spread of COVID-19 include social distancing, lockdowns and wearing face masks. Not all these are problematic, but some become an economic challenge to the majority of Africans as they live on hand-to-mouth income earned on a daily basis, which is not the case for the westerners. Another challenge is whether many Africans understand the meaning of social distancing. Do Africans really believe in it, given that face-to-face interaction dominates all aspects of life in Africa? How best can we understand social distancing? This paper argues that the failure to properly understand the implication of these measures is degenerating itself into another virus called the 'hunger virus'. The hunger virus is spreading way faster than the COVID-19 pandemic. To some extent, if all Africans were to fully practice social distancing, it would mean that most Africans will be stripped of the daily realities of business which is still largely informal. Furthermore, the paper asks whether the African people wear face masks, for example, and whether they even understand what COVID-19 is. These are general and foreign discourses predominantly from Western epistemic frames. This paper, therefore, argues for the critical deconstruction of what is really meant by COVID-19, social distancing and mandatory face masks as conventional public health requirements are significantly affecting the cross-border trade in developing countries.

Largely, the trade-related impacts of COVID-19 highlight the longstanding underutilization of the regional market by African countries. COVID-19 is negatively impacting intra-trade in Africa, and the sooner African people devise their context-specific solutions to this pandemic, the better would be the realization of the benefits of AFCTA. Many countries have imposed transportation and movements across the border, which implies challenges on the movements of

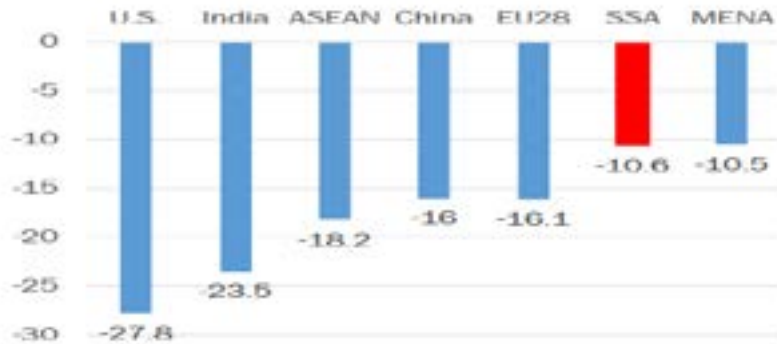
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goods and services by many Africans. Despite the fact that commodity price volatilities continue to dictate the direction of economic progress, the diversification of exports and increased value addition could help build resilience to shocks in African countries, especially in times of pandemics. Potentially, the full implementation of the African Continental Free Trade Area (AfCFTA), which will provide countries with opportunities for growth and economic diversification, particularly through industrialization and manufacturing, could be a game-changer for Africa. By addressing the fragmentation of African economies, in the longer run, the AfCFTA is also likely to boost agricultural outputs. According to the World Bank (2020b), the AfCFTA has the potential to increase intra-African exports of agricultural products by 49% by 2035 (compared to 10% growth without the AfCFTA), whilst also lifting between 30 and 68 million people out of poverty (UNCTAD, 2020).

## Trade Implications

COVID-19 will continue impacting trade globally in so many ways as the world is considered a global village. Since the 1990s, most countries around the world have opened up their markets to the rest of the world, and this has seen enhanced cross-border trade across the globe. With the liberalized system of opening up the borders to facilitate trade, goods, services, and products move from one country to another depending on the comparative advantage of each country. The ever-growing spread of COVID-19 across the globe is impacting cross-border trade with enormous travel restrictions put in place by each country. As if that is not enough, stringent border controls and production delays have weighed on trade. In other words, measures taken to slow down the COVID-19 outbreak have limited or delayed the supply of critical inputs, particularly in the automotive and electronics industries (Haren and Simchi-Levi, 2020; Baldwin and Tomiura, 2020). COVID-19 has also led to the collapse of airlines in most countries resulting in a steep rise in air freight costs, putting further strain on industries that rely on just-in-time delivery of foreign-sourced intermediate goods. Supplier delivery times have lengthened considerably, and inventories have been depleted (World Bank, 2020). The figure below shows the predicted change in exportations in selected regions and Africa together with MENA.

**Figure 1: Predicted change in exports in selected regions, 2020 (%)**



Source: WTO, (2020).

In showing how COVID-19 is impacting cross-border trade globally, the World Trade Organization (WTO), in its global forecast update of June 23 2020, estimated that global trade volumes could fall by 18.5% in 2020 and then recover in 2021 if COVID-19 reduces by then. This forecast partially reflects a downward revision from the WTO's more optimistic prediction of April 8 2020, in which it was forecasted that global trade volumes could decline by 13% to 32% in 2020 as a result of the economic impact of COVID-19 (WTO, 2020).

Furthermore, the COVID-19 pandemic has affected the labour force globally, which directly impacts the productive capacities of every country. McKibbin and Fernando (2020) argued that when calculating how the pandemic affects the labour shock, there is a need to adjust the problem in the model as an annual model. That is to mean, days lost at work, therefore, must be annualized. If we consider the current pandemic of COVID-19, it has a recommended incubation period of 14 days (ECDC; 2020), so we assume an average employee in a country would have to be absent from work for 14 days if infected (ECDC; 2020). This indicates a loss of productive capacity for 14 days out of the working days in a year. Hence, this can be used to calculate an effective attack rate of the pandemic for the globe and how this affects the productive capacities of economies that largely reduce or further contract the rates of exportation and importation across borders. In addition to labour shocks across the globe, there is also the shock of labour inputs. This study identifies other labour inputs such as trade, land transport, air transport and sea transport, which have been significantly affected by the outbreak (UNCTAD, 2019; McKibbin and Fernando, 2020).

COVID-19 has also affected commodity imports across the globe; nevertheless, the most affected in this commodity implication is the developing world with little or no strong financial fallback strategies. Growth in most commodity importers has been curtailed by severe domestic virus outbreaks and restrictions to stem the pandemic, all of which have heavily weighed on consumption and investment (World Bank 2020). Although commodity importers on average

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have more developed health care systems than commodity exporters, there is a considerable variation across regions.

COVID-19 is expected to impact China's global trade for several months. As China is Africa's largest trading partner, the effects of COVID-19 are already being felt in Africa (McKenzie, 2020). McKenzie continued arguing that, with countries like China that have a lot of trading ties with Africa having shut down their manufacturing centres and closed their ports, there has been a resultant decrease in demand for African commodities. Importers in China are cancelling orders due to port closures and as a result of a reduction in consumption in China. Sellers of commodities in Africa are being forced to offload products elsewhere at a discounted rate (McKenzie, 2020). He argued that over three-quarters of African exports to the rest of the world are heavily focused on natural resources, and any reduction in demand impacts the economies of most of the continent. McKenzie stated that countries such as the Democratic Republic of Congo, Zambia, Nigeria and Ghana are significantly exposed to risk in terms of industrial commodity exports, such as oil, iron ore and copper to China. The Organization of Petroleum Exporting Countries (OPEC) has dramatically reduced its outlook for oil demand this year as a result of the virus.

Arguably, McKibbin and Fernado (2020) indicated the most easily available indicators of the expected global economic impacts of COVID-19 reflected in the movements in financial market indices. Implications of the financial markets have a negative connotation on the availability of finances for investments in the productive sectors that have the capacity of expanding the exports of a country. For example, since the commencement of the outbreak, financial markets have continued to respond to daily developments related to the outbreak across the world. Particularly, stock markets have been demonstrating investor awareness of industry-specific (unsystematic) impacts (Prita *et al.*, 2020).

According to McKenzie (2020), the impact of COVID-19 will also be felt in the manufacturing sectors. Because China is part of the global supply chain, factory closures raise the risk of supply chain disruptions for multinational companies with delays, raw material shortages, increased costs and reduced orders, which are already affecting manufacturing plants around the world, including in Africa.

The COVID-19 pandemic is substantially impacting people's lives and livelihoods and putting extreme stress on socio-economic systems. International collaboration, coordination and solidarity among all are going to be the key to overcoming this unprecedented global challenge. The challenges argued by Wishnick (2010) are the same shortcomings being experienced in the COVID-19 pandemic.

One case study through which cross-border trade is affected in the COVID-19 period is that of South Africa. At this time, South Africa's deep integration into Southern Africa makes the region very vulnerable to any trade measures adopted by the country (SA Government Gazette, 2020). Delays at borders and export restrictions have impacted vital supply chains across this region and exacerbated the COVID-19 impact on fragile neighbouring economies. A second-round effect could well be a new wave of migration to South Africa, as those hit hard seek income opportunities

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elsewhere (SA Government Gazette, 2020). Largely, lockdowns and other restrictions, while necessary to slow the spread of the virus, have been accompanied by a sharp reduction in economic activity (Baldwin *et al.*, 2020; Boissay *et al.*, 2020; Eichenbaum *et al.*, 2020; Gourinchas 2020).

The World Trade Organization (2020) argued that there is a large degree of variation in terms of the products of which exportation has been prohibited or restricted. Many export restrictions and prohibitions affect the exportation of products that the joint WHO/WCO indicative list of products designates as essential in combating COVID-19 (WHO, 2020a). Largely, the COVID-19 virus and the efforts governments around the world are making to contain it are creating challenges for all companies that rely on global supply chains (Deloitte, 2020). While most countries have determined that cross-border trade of goods (as opposed to travellers) does not present a meaningful risk of spreading the virus and are doing what they can to reassure the trade community by keeping their borders open (again, for goods but generally not for people), trade is slowing down due to domestic efforts to contain the virus; the new normal is seeing limited instances of certain jurisdictions placing new restrictions on the export of personal protective equipment and other supplies needed to help combat COVID-19 (Sidley, 2020).

The COVID-19 pandemic has triggered a range of border controls in countries around the world to curb the spread of the disease. In Africa, these moves have interrupted progress toward economic integration (OECD, 2020b). The AfCFTA, for example, was supposed to establish a continent-wide free movement of goods starting on July 1, 2020. Later, the African Union Commission proposed postponing the launch until January 1, 2021. In addition, trade restrictions implemented in Africa and elsewhere in response to the pandemic are fuelling fears of a new food crisis on the continent (IFPRI, 2020).

However, it is worth indicating that most border closures have been imposed with little or no clear knowledge of what is happening on the ground. For example, in West Africa, because of daytime heat, fresh produce, meat, and other perishable products are usually transported at night. Yet, curfews make this practice impossible. Mandating more thorough health checks without adding necessary personnel also increases transport times. Health check delays and curfews are likely to cause significant waste and loss of products in West Africa (IFPRI, 2020).

Countries across the world are also facing serious consequences and damages to their economies. Many economies have faced negative per capita income growth in 2020 due to the Coronavirus pandemic, according to the International Monetary Fund [IMF] (2020). Furthermore, the International Monetary Fund's projections depicted that the global economy would contract sharply by -3% in 2020, much worse than during the 2008-09 financial crisis (IMF, 2020). In its later forecast, the World Trade Organization [WTO] (2020) indicated a clear fall in world trade between 13% and 32%, perhaps the highest fall since the Great Depression of the 1930s. There is also a disclaimer: no forecast is perfect when the pandemic is at its peak and changing the contours frequently.

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Furthermore, the world merchandise exports grew by just over 50% during the ten years between 2009 and 2019, reaching US\$18.9 trillion in 2019. Nevertheless, this growth experienced a 3% decline in 2018 (UNCTAD, 2020a). In 2017-2018, exports showed signs of recovery after more sluggish performances in 2015 and 2016, whereas in 2019, global services trade was valued at US\$6.1 trillion, recording a slight increase of 2% in 2018, and almost 70% in ten years earlier (UNCTAD, 2020a). These projections for 2020 were no longer possible because of the significant impacts on the world economy by the COVID-19 pandemic.

It is, therefore, worth noting that the year 2020 got off to a rocky start due to the COVID-19 pandemic. Preliminary UNCTAD-WTO estimates for the first quarter of 2020 showed a decline of 2.8% in world merchandise exports on the corresponding quarter in 2019 (UNCTAD, 2020a). The seasonally adjusted figures enabled comparison with the previous quarter and showed a drop of 2.0% for world export volume indices. Most of the impact of COVID-related confinement measures affected global trade during the second quarter of the year, for which UNCTAD estimated a decline of 26.9% from the previous quarter (UNCTAD, 2020b). From a development standpoint, such economic implications directly contract the livelihoods of the people particularly those of the vulnerable members of societies.

According to the UNCTAD (2020), developing economies have seen a strong recovery since 2017 after the 2008 global financial crisis and the more recent trade downturn in 2014-2016. Trade in goods increased at annual growth rates of 11.7% and 10.0% in 2017 and 2018, respectively. Trade in services grew by 9.0% in 2017 and 11.6% in 2018. While trade in services in developing countries continued to grow by 2.7% in 2019, trade in goods decreased by 3.5%. In 2018, total exports of goods and services reached US\$10.4 trillion but declined to US\$10.2 trillion in 2019. Thus, developing economies' trade finally exceeded US\$10 trillion, a level last achieved in 2014. Their trade has increased by almost 15% since 2015, the year the 2030 Agenda began. In 2020, global trade was expected to fall as the COVID-19 pandemic disrupted economic activities around the world. These disruptions will have profound implications for the most vulnerable economies, including developing economies and LDCs (UNCTAD, 2020c).

As if that is not enough, the pandemic has instigated a global economic downturn, the likes of which the world has not experienced since the Great Depression. GDP in the world's second-largest economy – China, fell by 6.8% between January and March 2020 (WEF, 2020). In the first quarter of 2020, China's exports and imports dropped sharply in volume compared to the previous quarter, by 21% and 11.5%, respectively (UNCTAD, 2020a). The consequences of the economic downturn in China were quickly felt in other economies as imports to and exports from China were reduced due to COVID-19.

As merchandise exports of LDCs are concentrated in a few markets, including those worst affected by the COVID-19 health crisis (China, France, Germany, the United States of America), it makes them even more vulnerable to a decline in demand in these countries. At an individual country level, LDCs are even more exposed to COVID-19 related economic disruptions. For example, in 2018, Angola exported around 57% of its merchandise to China, Benin around 41% to India, Burkina Faso around 54% to Switzerland, Haiti around 82% to the United States of America

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and Rwanda around 65% to the United Arab Emirates (WTO, 2020a). WTO reported that these statistics of trade have drastically reduced in 2020.

China is a major player in international trade as a manufacturer and exporter of consumer products and as a key supplier of intermediate inputs for manufacturing companies globally. Today about 20% of global trade in manufactured intermediate products originate from China (up from 4% in 2002). UNCTAD (2020d) has analyzed the UN Comtrade dataset for about 200 countries and 13 manufacturing sectors to measure each country's and industry's integration with the Chinese economy using the intra-industry trade.

The pandemic could also increase the trade finance gap by limiting access to forex liquidity required to finance African trade. In 2019, the trade finance gap in Africa was estimated at USD 82 billion (AfDB-Afrieximbank, 2020). If the pandemic persists, it could worsen the shortfall in liquidity experienced by banks engaged in trade finance in Africa. Foreign exchange liquidity shortages in the region could encourage global banks to reduce correspondent banking lines for domestic banks in Africa. This could limit the supply of dollar liquidity demanded by firms for trade, increase trade finance rejection rates, and increase the size of the trade finance gap in Africa above the USD 82 billion recorded in 2019 (AfDB-Afrieximbank, 2020).

According to this analysis, the economic downturn in China has led to disruptions in Global Value Chains (GVCs) and diverse spillover effects across economic sectors and countries (ECB Economic Bulletin, 2017). The crisis may impact the supply of critical parts from Chinese producers, affecting economic output and trade in any country dependent on the Chinese economy. These impacts may spread faster than expected due to the common strategy of limited inventories and just-in-time production compounded by COVID-19 trade restrictions (WTO, 2020).

On the other hand, the WTO has been monitoring the trade-related measures governments have introduced in response to the COVID-19 pandemic. A significant number of these measures are temporary export restrictions imposed on medical goods. There have also been several trade-facilitating measures, such as the temporary and unilateral withdrawal of tariffs to facilitate imports of these products (WTO, 2020a). Some non-tariff measures associated with trade in these goods (for example, the elimination of non-automatic licensing procedures or the introduction of special export licensing requirements) are also being taken by members to combat the impact of the crisis (WTO, 2020).

Baldwin (2020) argued that 2020 would experience a more severe trade turndown than the demand shock of the 2008-2009 crisis as the COVID-19 crisis creates both a demand and supply shock. From the supply perspective, production is affected for two reasons: because of reductions in labour supply and because of disruption to value chains. Countries that rely on equipment and components from regions affected by the virus may experience disruptions in the production process (EIF, 2020). From the demand angle, demand for manufactured goods could fall considerably. During lockdown, many shops are closed, and people are reducing shopping in-person to avoid social contact. Workers who are required to stay at home in line with "social

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distancing” measures tend to prioritize saving over spending; thus, the propensity to consume decreases. Secondly, firms that are experiencing disruptions in the production process may decrease their consumption of intermediate goods.

Small and vulnerable economies are likely to be hit hard because of their dependence on trade as a driver of economic growth, their small domestic markets and low levels of diversification, all of which increase their vulnerability to external shocks, as the global financial crisis demonstrated (Keane, 2020). That said, the impact of supply and demand shocks on trade can be manifested in different ways depending on the country or region. It is plausible to assume that resource-rich developing countries will also be affected by the strong reduction in commodity prices, for example, the fall in the prices of petroleum and precious metals caused by reduced international demand for such goods, and that developed countries have been experiencing a drop in the production of transformed manufactured goods (see Towards sustainable industrialization and higher technologies) (UNIDO, 2020).

However, the impact of the COVID-19 pandemic will be similarly devastating for LDCs and other developing countries that do not rely on commodities as a primary source of their foreign revenues (World Bank, 2020). Non-commodity dependent LDCs, such as Bangladesh, Cambodia and Haiti, rely mostly on low-skilled and labour-intensive manufacturing exports, which are at risk of contracting sharply if global demand for manufacturing exports remains depressed in 2020 and beyond. Also, the lack of sufficiently large domestic demand to absorb excess supply as external demand drops is likely to lead to mass layoffs of the labour force in the manufacturing sector (UNCTAD, 2020a). Much of the exports of these countries rely on intermediate imports from abroad, meaning that if the disruption in global production and supply chains continues, these economies may not be able to procure intermediate production inputs, even if there is demand for their products (WTO, 2020).

Largely, border restrictions by governments led to an abrupt slowdown and delays in cross-border trade, often characterized by disputes between neighbouring countries, long lines of trucks awaiting clearance and the divergence of trade to less safe unofficial routes. Informal cross-border trade, which requires traders to cross the border to sell their goods and services on the other side, has been particularly hard hit (Luke *et al.*, 2020). Disruptions to cross-border trade present significant challenges for Africa’s fight against COVID-19 and broader socio-economic development.

The World Bank (2020) further argued that the COVID-19 pandemic is expected to hit African economies extremely hard. According to the World Bank biannual Africa’s Pulse report, as a result of the pandemic, economic growth in sub-Saharan Africa will decline from 2.4% in 2019 to between -2.1% and -5.1% in 2020, depending on the success of measures taken to mitigate the pandemic’s effects. This means that the region will experience its first recession in 25 years. The decline will be primarily due to large contractions in South Africa, Nigeria, and Angola based on their reliance on exports of commodities whose prices have crashed as well as other structural issues (OECD, 2020). This will inevitably affect Africa’s participation in trade and value chains as well as reduce foreign financing flows.



## Trade Opportunities during COVID-19

The spread of the pandemic has essentially halted international travel and disrupted global value chains, resulting in a sharp contraction in global trade. Nevertheless, opportunities arise amidst the COVID-19 pandemic where countries and communities across the world have taken different approaches in the quest for not only reducing the spread but also eliminating the virus. It is, therefore, safe to argue that the COVID-19 crisis is an opportunity for policymakers to learn from each other and co-operate to mitigate the effects of the pandemic and maybe even “build back better”. The paper further recommends that all development stakeholders must join hands and support each other in the fight against COVID-19.

Even though trade allowed COVID-19 to grow from epidemic to pandemic and attack more peoples of the world, trade itself has not escaped from the economic damage of COVID-19 (WTO, 2020). Trade, which involves movements of the people, goods, products and services across the borders, led to the fast spread of the virus globally, and in reverse, this has affected trade itself via various restrictions imposed by individual countries. There is, however, a question that is asked about where Africa’s future markets and trading opportunities are. As the old saying goes, “crisis is also an opportunity.” This time is no exception. African countries can build more resilient and sustainable economies if they can do things right following the pandemic. As Zeng (2020) cited in the World Bank (2020) argued, at least four optional policies exist during this pandemic.

Firstly, there is a need for further diversification of the African economies and strengthening the few strategic sectors. The pandemic crisis has not only highlighted the importance of food and health sectors, but it has also exposed the dysfunctional aspect of these sectors in most countries. Africa is uniquely positioned to further leverage its rich agricultural resources by improving basic infrastructure and efficiency and agro-processing capacity (FAO, 2017). More resources will be needed to strengthen the public health sectors with the support of development partners. In this regard, the two sectors must go hand in hand for a successful enhancement of the people’s livelihoods (World Bank, 2020).

Secondly, Africa must embrace the digital age and adopt more and more digital technologies for both productions and services, such as banking, retailing, learning, and public services. The sectors with a high level of digitization seem to weather the storm much better. In doing so, it needs to strengthen its education system, especially the training and learning related to digital skills (World Bank, 2020).

Thirdly, through the AfCTA, Africa as a continent has an opportunity of strengthening intra-regional trade in the quest to balance supply and demand. For Africa to boost the intra-regional trade, countries need to make not only concerted efforts but must also have the political will of ensuring harmonization in their trade-related regulations, customs controls and reduce both tariff and non-tariff barriers (United Nations Economic Commission for Africa, 2017). Meanwhile, countries must also be ready to willingly invest and improve their infrastructures and connectivity to lower the logistics cost. This crisis provides an opportunity to take more concrete steps towards realizing the African Continental Free Trade Area (AfCFTA) (World Bank, 2020).

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Finally, as African countries have a large market within and amongst themselves, there exists an opportunity for expanding intra-African trade during and after the pandemic. The pandemic came with a lot of restrictions as far as cross-border trade is concerned. This is at the detriment of African countries whose majority of trade is with the Western world. Trade restrictions with China due to COVID-19 revealed that most countries have challenges on the availability of goods and services in their markets. If African countries could exploit the opportunity of trading within and amongst themselves throughout this pandemic, they would stand a chance of stabilizing their economies.

Also, trade volumes for Africa are projected to decrease by 8% for exports and about 16% for imports for 2020, compared with previous historic trend estimates (WTO, 2020b). As a result, Africa is expected to be hit particularly hard as 17% of the world's 'COVID-induced' poverty will be located on the continent following East Asia, the continent with the highest concentration of 'new poor' (20%) (Sumner et al., 2020). Last but not least, Africa, during the pandemic, can expand more on international trade agreements that can support its growing but still fragile export sectors (World Bank, 2020).

## Conclusion

In conclusion, this paper argues that international trade plays an important role in the economy of each country. Trade allows the satisfaction of the needs of the population and stimulates internal development making the economies of developing and developed countries highly interdependent. COVID-19, a global pandemic, has affected and impacted trade across borders. Trade across borders in Africa has contracted more because Africa has taken the conventional approach to mitigate COVID-19 without critically analyzing their specific socio-political and economic dynamics. Africans are affected not only by lack of proper understanding but also by the fact that the majority cannot afford face masks, and even when they have masks, most of them might not put them on. Subsequently, the poor are likely to suffer disproportionately from the outbreak as they may have less access to healthcare and also lower savings to hedge themselves against financial catastrophe. Lack of an African ideological perspective to reduce the spread of the virus without affecting the socio-economic dynamics (and considering that most people depend on daily income) has also affected both intra- and cross-border trade in Africa. Therefore, the unavoidable decline in trade and output will have painful consequences for households and businesses, on top of the human suffering caused by the disease itself. The COVID-19 pandemic is causing the worst contraction in global trade in the post-war era. One of the affected sectors is the industrial sector through the global value chains (GVCs). Industries that participate in GVCs are often dependent on "just-in-time" delivery of intermediate inputs, and trade of such inputs has been restricted and, in some situations, closed due to lockdowns.

This paper concludes that COVID-19 has affected economies differently. Some of the manifestations include the slowing down of the manufacturing of essential goods, disruption of the supply chain of products, losses in national and international business, poor cash flow in the market and a significant slowdown in revenue growth. The social consequences include the cancellation or postponement of large-scale sports and tournaments, disruption of celebration of

cultural, religious and festive events, undue stress among the population, social distancing with peers and family members, closure of hotels, restaurants and religious places, closure of places for entertainment such as cinemas, theatres, and sports clubs. The above effects of COVID-19 largely affect trade within communities, nations and across borders, but most importantly, the pandemic has generally affected the Intra-African trade, which is the aim of the AfCTA.

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# The Consequences of COVID-19 on Human Rights and Freedoms

Mutsa Murenje and Shauna Kimone Porter

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## Abstract

This qualitative desktop study relied on existing literature to gain concise knowledge of the consequences of the Coronavirus disease (COVID-19) on fundamental human rights and freedoms in Africa. Informed by the cardinal social work principles of human rights and social justice, which have their genesis in humanitarian and democratic ideals founded on such values as dignity, equality, the study highlighted the brutalities being imposed on African nationals in their countries owing to the COVID-19 pandemic. The study proposes recommendations to remedy these while advocating for a comprehensive human rights approach, among other measures, in responding to the pandemic.

## Keywords

Coronavirus, dignity, freedom, human rights, social justice

## Introduction

Pandemics have persisted throughout human history. Major ones include the Antonine Plague (165-180), Human Immunodeficiency Virus (HIV)/Acquired Immuno-Deficiency Syndrome (AIDS), Swine Flu, Severe Acute Respiratory Syndrome (SARS), Ebola, Middle Eastern Respiratory Syndrome and more recently COVID-19 (LePan, 2020). Over a short period, COVID-19 has transformed lives and the global landscape, thereby leaving governments, public health authorities, healthcare professionals and researchers all struggling to combat and adequately comprehend the pandemic (Weir, 2020). The pandemic has been described as ‘... the defining global health crisis of our time ... [and brought about] an unprecedented socio-economic crisis’ (United Nations Development Programme [UNDP], 2020).

Consequently, now more than ever, our world is in dire need of guidance and assistance from the consequences of the pandemic. This article interrogates the implications of the disease on the observance of fundamental human rights and freedoms in selected African countries from a qualitative perspective. Reliance was made on secondary sources of information as the collection of primary data was limited due to travel restrictions. The article, therefore, contains materials

subjectively selected and included because of their relevance to the topic under study. Finally, the article also makes a compelling case for constructive and innovative responses to the pandemic.

## **The human rights implications of COVID-19 in African states**

Increasingly, disease outbreaks draw considerable public attention, often characterized by sensationalism in the lay press, with a rapt focus on the origins of the epidemic, rates of infection and associated mortality rates (Bausch & Clougherty, 2020). However, the discourse on 'the human rights elements [or dimensions] that consistently underlie large outbreaks of these dangerous [diseases]' (Bausch & Clougherty, 2015) is marginal. This study, therefore, interrogates the intersection between COVID-19 and human rights and freedoms in Africa by highlighting key debates about these humanitarian and democratic ideals. The latter section identifies and explores several remedies that may be deployed to increase respect for and protection of fundamental human rights and freedoms, consistent with the international human rights conventions and municipal laws in respective countries. As reflective social work practitioners, it is also our considered view that the suggested remedies can alleviate poverty, meet human needs, develop human potential, and promote the social inclusion of oppressed and vulnerable people (British Association of Social Workers, 2021).

## **Rights to Health, Education, and Life**

COVID-19 poses severe health, education, and life threats due to its biomedical and public health emergency nature. It has well been reported that the pandemic has aggravated poverty, access to quality education and health services in many countries (United Nations [UN], 2020a). This state of affairs has triggered waves of concerns among interest groups and multilateral organizations given the implications for vulnerable groups, struggling economies and nation-states that cannot realize and protect the human rights of their citizenry (African Union [AU], 2020a; Lone & Ahmad, 2020; UN, 2020a). Considering the mayhem the pandemic has caused in the most developed parts of the world, Lone and Ahmad (2020) and Zambara (2020) predicted a dire situation in the Global South owing to diabetic and virtually non-existent healthcare infrastructure and equipment.

Indubitably, pandemics such as COVID-19 pose fundamental threats to public health as they strain available medical facilities (Izobo & Abiodun, 2020). COVID-19 has highlighted the severe lacunas inherent in accessing essential healthcare services in countries of the Global South, particularly in Africa. It hinders and inhibits the efficacy of healthcare professionals in fulfilling their obligations primarily due to a lack of resources precipitated by inadequate investments in health (Human Rights Watch [HRW], 2020a). To avoid doubt, insufficient investments in healthcare equipment and infrastructure have led to a massive brain drain as African nations grapple to retain healthcare professionals, provide essential medicines and drugs and reduce death rates from ever-present diseases such as malaria. Most healthcare systems throughout Africa are neglected and poorly resourced as there are fewer hospital beds, intensive care units, and healthcare professionals compared to other regions (HRW, 2020a). To illustrate this, most African nations struggle to contain the spread of COVID-19 despite budgetary cuts, inadequate

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allocation of funds in healthcare services and poor planning. In North Africa, for instance, states and governments were unprepared for the pandemic, and health expenditure had been reportedly reduced for decades. Countries like Tunisia had a paltry 200 intensive care beds; Morocco had only 550 respirators; and Libya lacked resources in Tripoli and its satellite towns (Joffé, 2020). The situation was equally dire in West Africa, where nine of the 25 poorest nations in the continent were found. Health systems were poorly funded, thus rendering them ineffective in scaling up quick responses to the pandemic. In this region, many countries are said to have less than ‘five hospital beds per 10,000 of the population, and per capita health expenditures are lower than US\$50’ (Martinez-Alvarez *et al.*, 2020). As a result, as of May 5, 2021, the African continent had an estimated 123,554 COVID-19 related deaths, South Africa being the worst affected, with about 54,557 deaths or 44.2% of total deaths on the continent (Statista, 2021). Egypt and Tunisia followed with 13,655 deaths and 11,122 deaths, respectively. Statista further reported that the continent also recorded 4.63 million cases on the same day. Thus, while saving lives is imperative during pandemics, the dearth of testing kits made this virtually impossible (HRW, 2020a). Despite their swift responses to mitigate the spread of COVID-19, many countries faced immense challenges as they lacked the ‘capacity to test for COVID-19, isolate people with confirmed or suspected cases, trace contacts, and treat those with severe illness’ (HRW, 2020a).

## Stigma and discrimination

The UN (2020) reported that stigmatization and discrimination hinder people with COVID-19 symptoms from accessing healthcare services, including testing. WHO (2020a) concurred with the report by asserting that stigma and discrimination are rife and rampant during public health emergencies and are often ‘directed at persons diagnosed with COVID-19, at people of Asian descent or [at those] who have travelled to affected countries ... [and] healthcare professionals’ (WHO, 2020a). There are serious fears that associating the Coronavirus with a particular country could lead to xenophobia, discrimination, racism, and attacks (Wintour, 2020). WHO (2020a) warned that stigma and discrimination have grave mental health and physical consequences for the affected populations and their communities. This was also the case with HIV and AIDS when they were first experienced. Novogrodsky (2009) wrote that early efforts to contain the effects of the HIV and AIDS pandemic were aimed at destigmatization and anti-discrimination. Similarly, noting that Ebola was ‘the deadliest and most terrifying epidemic of recent memory’ (Shu-Acquaye, 2017), its entrenchment in Africa was blamed on cultural practices exacerbated by stigmatization and weak human rights laws. Shu-Acquaye argued that these factors had made the elimination of the disease in Africa intricately complex.

## Marginalized groups

In light of the dynamics above at play, it is hardly surprising, therefore, that worldwide, COVID-19 has had disproportionate and deleterious effects on highly disadvantaged populations, including the poor, sexual and gender minorities, the criminalized, the sick, the elderly, those facing perennial exclusion and discrimination, the homeless, internally displaced persons, migrants and refugees (Guterres, 2020; Sebastian, 2020; Tsai & Wilson, 2020; UN, 2020; Vearey, 2020;

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WHO, 2020a). The United Nations High Commissioner for Refugees (UNHCR) (2020) reported that Coronavirus had aggravated the plight of refugees fleeing persecution, conflict, and war. The refugee agency further noted that countries are putting human rights and refugee law at risk as they seek to protect their economies and populations. As such, an estimated 167 states had partially or fully closed their borders to slow down the spread of the pandemic, while at least 57 states had made no exception for asylum seekers. Given the ongoing violence and wars in most parts of the world, border closures hinder people from seeking asylum, while forced repatriations and transfers are taking those seeking safety and shelter to countries where their lives and freedoms face substantial threats. The situation was grave as the UNHCR witnessed:

A disproportionate use of immigration detention, a rise in the risk of sexual violence, discriminatory restrictions on access to health and social services and a dramatic loss of livelihoods drive many refugees and others on the margins of society deeper into poverty and destitution (UNHCR, 2020).

Sadly, a paucity of literature exists about the homeless, the elderly and people living with disabilities (UN, 2020). There is no doubt, however, about their exposure to 'increased morbidity and mortality' (Armitage & Nellums, 2020). Wakene (2020) believed that in Ethiopia (East Africa), COVID-19 has severely affected people living with disability, most of whom are poor. He attributed this state of affairs to the disproportionate exposure of people with disabilities to COVID-19 due to their disabilities and living conditions and to what he described as 'the infinitesimal attention given to the matter in systemic responses to the pandemic' (Wakene, 2020). In Southern Africa in general and South Africa in particular, Mulibana (2020) decried the exclusion of people with disabilities in COVID-19 responses, arguing that lack of consultation had led to their neglect despite the existence of a comprehensive legal framework to advance disability rights. Significant objections were equally raised against forced evictions and the demolition of shack dwellings in informal settlements in Johannesburg. Makgale (2020), for example, vehemently argued that removals in Johannesburg were exposing the most vulnerable to increased health risks and hardship. She opined that citizens were in dire need of safety and security and could not be forced to confront the highly contagious and pernicious COVID-19 pandemic without shelter while being exposed to the ugly brutalities of homelessness. Despite the absence of information regarding homeless persons, some studies, as already discussed, have reported the calamitous socio-economic, educational, and health effects of COVID-19 on children and families. It has been observed, for instance, that homeless children cannot observe social distancing due to squalid living conditions and overcrowding (Rosenthal, Ucci, Heys, Hayward, & Lakhanpaul, 2020). Without a doubt, overcrowding and squalid living conditions provide a fertile ground for COVID-19 exposure and transmission. Scholars have found the risk of contagion to be extremely high in congregate detention facilities (Dersso, 2020; Keller & Wagner, 2020; Kinner *et al.*, 2020).

There has been growth in domestic violence cases (WHO, 2020a; Wintour, 2020; Zambara, 2020). WHO (2020a) asserted that extant social and gender disparities affect women and girls differently from men and boys, and COVID-19 has aggravated these (see also Dersso, 2020; Kagumire & Ouya, 2020; Warega & Ilori, 2020). Nyamao (2020), for instance, wrote that stringent travel

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policies and lockdown measures had far-reaching effects on women's rights on the continent. She argued that most women eke out a living in the informal sector, where they take up positions as street retailers, tailors, hairdressers, casual workers, and subsistence farmers. She further posited that women in non-agricultural jobs constituted 74% of people in informal employment, where they face even more challenges due to COVID-19. She wrote thus:

Working in the informal economy often leaves women without any protection of employment or labour laws, social benefits such as unemployment funds, health insurance, paid sick leave and paid leave of absence. They typically work for minimal wages and in hazardous conditions. The situation can be worse during this pandemic since women are at the front line and are the majority of caregivers (Nyamao, 2020).

Women and girls' access to sexual and reproductive healthcare services is affected by ongoing restrictions on their mobility and the dire economic challenges their households face. In Zimbabwe, for example, Amnesty International (2021) reported women being denied access to essential maternal healthcare while violence against both women and girls was widespread. In particular, the first 11 days of the lockdown in 2020 saw 764 cases of violence against Zimbabwean women and girls being recorded. These cases had risen to 2,768 by mid-June. What was concerning was the Zimbabwean government's failure to prioritize services to protect women and girls from such attacks. As a result, they were denied prompt access to justice (Amnesty International, 2021). The United States Embassy in Zimbabwe (2021) concurred with its 2020 human rights report in Zimbabwe. It identified an increase in crimes involving violence or threats against women and girls and a lack of investigation of and accountability for violence against women as some of Zimbabwe's most significant human rights issues. Without a doubt, such curtailments represent a flagrant violation of their fundamental human rights. Likewise, women and girls have further been exposed to an intimate partner or domestic violence due to the limitations above on their movements. Domestic violence also forms a gross violation of human rights. It is incandescently clear that women and girls continue to bear the brunt of the COVID-19 pandemic. Even though no specific countries were mentioned, Sebastian (2020) observed some of the challenges women faced owing to the pandemic and wrote that:

Women sick with COVID-19 symptoms are prevented from visiting a clinic because they cannot contact men other than their husbands, and they [are] not allowed to stay in hospitals alone. Police officers are detaining and fining people living with HIV, trying to secure antiretrovirals during a lockdown.

## **Democratic freedoms in selected states**

The International Federation for Human Rights (FIDH) (2020) noted that governments across the globe had deployed a series of extraordinary measures in their response to the COVID-19 pandemic. These measures range from surveillance to closed borders and authoritarian responses (Wintour, 2020). Nonetheless, the FIDH expressed serious concerns over the scope, duration, and nature of the said measures. Much focus has been on the measures' implications on human rights and democracy itself (Kapapelo, 2020; Simiyu, 2020). For instance, Cheeseman and

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Smith (2020) decried the scant regard for the repercussive effects of COVID-19 on democratic freedoms. Elections and related political activities have been postponed in several African countries in East Africa, North Africa, Southern Africa, and West Africa due to the risks and uncertainties of COVID-19. Therefore, there can be no doubt that COVID-19 is affecting normal socio-economic and political activities on the African continent, although governments have always adopted extraordinary measures in public emergencies. The ravaging effects of the 2014 outbreak of Ebola in West Africa compelled governments to enforce measures they believed would aid in containing its spread. Durojaye and Mirugi-Mukundi (2015) felt that some of the deployed steps were drastic and had ‘implications for the fundamental rights of individuals ... [and that the Ebola outbreak had highlighted] the tension between public health and human rights.’

Furthermore, concerns have been raised regarding the long-term measures that deepen and broaden the depth of human rights restrictions in several nation-states. It would appear that issues unrelated to COVID-19 are receiving too little attention. At the same time, governments have taken advantage of the pandemic to unconstitutionally expand and retain their powers, control populations, and make brazen attacks on fundamental human rights and individual liberties (FIDH, 2020). In other words, authoritarian states are taking advantage of the pandemic to violate individual liberties and repress the free flow of information, thus turning an essentially ‘public health emergency into a human rights crisis’ (Wintour, 2020). As Cheeseman and Smith (2020) observed:

In some countries, leaders responded so rapidly that critics fear they are manipulating the crisis to consolidate their political power. Most notably, governments in Malawi (Southern Africa) and Uganda (East Africa) banned public gatherings – and hence opposition rallies and civil society protests – before their countries had recorded a single case. Their counterparts in Guinea (West Africa) and Zambia (Southern Africa) are using the cover of the Coronavirus to advance their authoritarian agendas and prolong their time in office. This creates a stark problem for opposition parties and independent civil society groups because the same measures are taken to tackle the pandemic also undermine their ability to defend democracy. Pro-democracy forces across Africa are thus being kneecapped – and often violently – under the expedient guise of public health and national security.

Further compounding the abilities of civil society organizations and opposition political parties to organize and defend democracy is that their operations and funding sources have been severely curtailed by lockdown regulations, even as major donor and aid agencies are changing their priorities. Political dissent is negatively portrayed as a severe threat to public health and national security and continues to face violent reprisal from autocratic regimes and overzealous, often partisan security forces. Activists and journalists are systematically targeted on social media in Algeria while being harassed and deported from countries like Egypt (North Africa), Rwanda, and Somalia (East Africa). In Zimbabwe (Southern Africa), supporters of the opposition, Movement for Democratic Change—Alliance, have been prevented from challenging a very controversial ruling by that country’s supreme court that nullified Nelson Chamisa’s leadership of the party (Cheeseman & Smith, 2020). This situation represents an unfortunate situation, a double tragedy,

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so to speak (Zambara, 2020).

Under states of emergency, countries create conducive conditions for flagrant violations of human rights. State of emergency declarations or lockdown enforcement measures imposed in various nations to contain the spread of COVID-19 has had serious negative ramifications on fundamental human rights and freedoms, particularly on those relating to life, health, education, freedom of movement, association, and expression (Green, 2020; UN, 2020a). Yet, Molloy (2020) maintained that a state of emergency declaration is necessary as it facilitates the safeguarding of national security, maintenance of law and order, protection of lives and property, keeping of essential public services running, directing of relief efforts to areas with the greatest need, and restoration of normalcy. Nonetheless, he cautioned that despite its flexibility in responding to public emergencies, a state of emergency declaration is accompanied by significant human rights risks such that '[e]mergency powers must be monitored scrupulously and on an ongoing basis' (Molloy, 2020). However, governments, especially those in Africa, are notorious for abusing power by resorting to suppression of dissent to entrench autocracy (Zambara, 2020). Abrogation of fundamental human rights in Africa is pervasive during even the most peaceful times, and it is worse now given the COVID-19 pandemic. Green (2020) reported that freedom of movement had been curtailed in more than half of Africa's 54 nations in a bid to contain the spread of the Coronavirus pandemic. Adegalu (2020) also contended that 'alongside the right to freedom of movement, the right to assembly...has been severely limited, restricted or prohibited by most African states as part of measures adopted to address the spread of COVID-19' (para. 8). For instance, some countries imposed partial lockdowns while others opted for absolute ones. This has been the case in Ethiopia, Kenya, and Rwanda in East Africa, Nigeria in West Africa, and Seychelles, South Africa, and Zimbabwe in Southern Africa (Adegalu, 2020; Dube, 2020; Green, 2020; Izobo & Abiodun, 2020; New Zimbabwe, 2020; UN, 2020; Wakene, 2020; Zambara, 2020). These restrictions on movement raise serious concerns regarding the observation and protection of human rights as some security forces resort to outright violence and brutality. Mudau (2020) wrote that constitutional rights relating to freedoms of assembly, movement, association, the right to privacy, access to information, and the right to bodily and psychological integrity had been severely curtailed in South Africa in a manner inconsistent with the country's constitution and its cardinal founding values of equality, freedom, and dignity. This created an alarm that South Africa might be slowly becoming a surveillance state. Mudau (2020) writes:

This broadly-phrased power raised the spectre of state surveillance using digital location and interception of communications, which were reminiscent of apartheid-era spying and movement control, as well as of more recent political abuses of state security capacity. The state's will to prevent the increase in COVID-19 infections and deaths is not proportionate to the cruel and degrading retributions meted out by enforcement officers who preside over pervasive physical violence on citizens (Mudau, 2020).

Security forces reportedly killed seven civilians in Kenya, eight in South Africa, while a police officer beat a taxi driver in the Democratic Republic of Congo (Southern Africa). In Burundi



(East Africa), thousands of civilians were forcibly detained in wretched and squalid conditions in camps where they had severely restricted access to food, water, and sanitation (Green, 2020; Wintour, 2020). The Ugandan government took advantage of the pandemic to crack down on sexual minorities. At the same time, a private television station had its licence revoked by the government in Zambia when it refused to air free COVID-19 awareness adverts (Green, 2020).

The situation in Zimbabwe reminded people of the Rhodesian and Gukurahundi atrocities (New Zimbabwe, 2020). Although the late Zimbabwean President, Robert Mugabe, was heavily criticized for severe human rights abuses during his time, it would appear that his successor, Emmerson Mnangagwa, has taken the country in a very retrogressive, oppressive, and anfractuous direction that threatens not only the people's fundamental freedoms but also their very lives. Many Zimbabweans and international observers had hoped that Zimbabwe would swiftly move from an oppressive dictatorship to a constitutional democracy when Mugabe was removed from power in a military coup in November 2017. However, the reality is that it is becoming increasingly evident that the post-Mugabe situation in Zimbabwe has worsened. Feldstein (2018) contended that 'Mnangagwa and his allies did not force the ailing Robert Mugabe out of office to transform Zimbabwe's political system. Rather, they sought to ensure their continued control over the nation'. For instance, Mnangagwa has retained the legal, security, and administrative architecture Mugabe used to consolidate his militaristic rule. As such, authoritarian tendencies and repression have worsened as Mnangagwa uses the Maintenance of Peace and Order Act to place heavy restrictions on freedom of assembly (Freedom House, 2021). HRW (2021) also noted the continued decline of the human rights situation in Zimbabwe in 2020. The rights organization reported that:

Unidentified assailants, suspected to be state security agents, abducted and tortured more than 70 critics of the government in 2020. Security forces also continued to commit arbitrary arrests, violent assaults, abductions, torture and other abuses against opposition politicians, dissidents and activists. In July, the police violently dispersed protests, wherein 16 protesters were injured, and a further 60 were arrested (HRW, 2021).

The AU (2020a) was overly concerned about political developments in Zimbabwe especially given the country's socio-political and economic hardships. The African Union Commission (AUC) Chairperson, Moussa Faki Mahamat, released a statement urging the Zimbabwean government to fulfil its obligations under the African Charter on Human and Peoples' Rights and the African Charter on Democracy, Elections and Governance. Mahamat called for restraint from the security forces whenever they responded to peaceful protests during these times of the COVID-19 pandemic and reaffirmed the AU's support for the people of Zimbabwe as they endeavoured to deepen democracy in their country. So serious was the situation in Zimbabwe that Harding (2020) observed:

The impoverished nation seemed to be turning a corner three years ago when the military forced President Robert Mugabe out of power. His successor, Emmerson Mnangagwa, promised tough economic reforms and a new era of transparency and

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accountability. But today, half the country's population is struggling to feed itself, high inflation rates have returned, and [the ruling party] has stopped telling the world that Zimbabwe is *open for business* and has reverted to its old habit of accusing unnamed Western nations of fomenting unrest and of conspiring with local critics to undermine the government and the economy.

Zambara (2020) described the situation in some African states as follows:

In South Africa, numerous human rights complaints have been made since the first day of lockdown, including one suspected case of murder. In Rwanda, five soldiers were arrested allegedly for raping women. In Kenya, President Uhuru Kenyatta apologized for *police excesses* that included the murder of a 13-year old boy. In Nigeria's Delta State, a person was killed for allegedly flouting lockdown rules. In Uganda and Zimbabwe, several videos circulated of security forces beating and torturing people in broad daylight. In many countries, we have trigger-happy, truncheon and teargas-enthusiastic police officers whose appetite to apply pressure before logic is insatiable...they instil more fear among the people they should protect than what Coronavirus would do.

## Recommendations

Given the primary challenges associated with the COVID-19 pandemic, especially concerning its detrimental effects on the protection of human rights in Africa, this desktop study has identified several remedies that may be deployed to increase respect for and protection of fundamental human rights and freedoms as is consistent with international human rights conventions and municipal laws in respective countries. In the African context, the measures employed will have to be consonant with the African Charter on Human and Peoples' Rights for them to effectively mitigate the pernicious effects of COVID-19 on socio-economic rights and political freedoms. This study believes that such remedies and strategies are needed now, and in the future when dealing with other pandemics that may befall the African continent. The AU has since shown its commitment in this regard, as exemplified by its advertised webinar whose objectives intended to:

provoke a reflection on the role of the AU Organs in supporting AU Member States to realize their human rights obligations during the pandemic crisis, to identify lessons learned and best practices in prevention and response to COVID-19 and to inform a more enhanced and comprehensive response during the present and future health emergencies (AU, 2020b).

Given Africa's experience with other pandemics, it must diligently understand the present, considering its past experiences with pandemics such as Ebola, HIV and AIDS, identifying opportunities and challenges as a form of best practice modelled by the UNDP (UNDP, 2020).

## The need for a comprehensive human rights approach

There is a broad agreement that the COVID-19 pandemic has a devastating effect on the human rights situation in many African countries today. Most non-government organizations are renowned for their inherent focus on civil and political rights. Although desirable, a more compendious human rights approach will pay more significant dividends for the affected countries (Sebastian, 2020; UN, 2020). Integrating human rights in responses to the pandemic is imperative and essential in setting 'the foundation for how the world responds to public health crises going forward' (WHO, 2020a). As mentioned earlier, the AUC Chairperson addressed the Zimbabwean situation promptly, amid growing concerns, by issuing a statement in which he reminded the Zimbabwean authorities of their obligations and how they ought to deal with protests in the context of the pandemic. The implication of this is obvious. Human rights organizations need more support to tackle COVID-19 related issues and strengthen their response against authoritarianism and gross human rights violations (FIDH, 2020). Also, instead of only focusing on civil and political rights, national human rights institutions must pay sufficient attention to socio-cultural and economic rights. The African Commission on Human and Peoples' Rights released a statement on February 28, 2020, in which it called on African states to prioritize preventive public health initiatives such as the provision of water and sanitation, and facilitation of access to information and public participation, in accordance with human rights obligations (Dersso, 2020). Tunisia sought and received funding from the International Monetary Fund, estimated at \$745 million, and distributed an estimated 30 million face masks. In comparison, Morocco came up with a \$3-3.4 billion special fund to respond to the pandemic (Joffé, 2020). The South African government urged municipal authorities 'to stop shutting off water for non-payment and is distributing water by tanker to informal settlements and other communities in need' (HRW, 2020b).

Pandemics are known to threaten the very existence not only of the global order but also of states that have limited guarantees of socio-economic rights and weak healthcare systems (Abe, 2020). As Sebastian (2020) wrote:

Socio-economic equality, issues of food security, adequate shelter, privacy protections, protection against discrimination—these concerns cannot be ignored to address the COVID-19 pandemic, as that would lead to a worsened global response, poorer health outcomes, and increasingly fractured and disadvantaged communities in the future.

*In pari materia*, UNAIDS (2020) also weighed in on the inherent need for a comprehensive human rights approach in containing the COVID-19 pandemic. The response to COVID-19 needs to consider people's lived experiences and prevent the obstacles they face in their attempt to protect themselves and their communities. Considering the above, the Zimbabwean President recognized the importance of housing during these trying times by granting a moratorium on residential evictions owing to failure by tenants to meet rental obligations for the entire lockdown period, beginning from April 2020 (Shava, 2020). Further, in an attempt to keep the public informed and to mitigate obstacles to testing, treatment, and care, the Ethiopian government 'lifted a blanket ban on telephone and internet service in the western Oromia region, ending a three-month-long shutdown, giving those communities access to life-saving information' (HRW,

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2020b). Nation-states should ensure that lockdown restrictions are time-bound and proportionate, 'with a specific focus and duration' (Wintour, 2020). Targeted quarantine measures and effective testing can reduce unnecessary limitations on mobility, and restrictions on movement should be lifted whenever the initial reason for their imposition no longer exists. In other words:

Empowerment and guidance, rather than restrictions, can ensure that people can act without fear of losing their livelihood, sufficient food being on the table and the respect of their community. Ultimately it will give us a more effective, humane and sustainable response to the epidemic (UNAIDS, 2020).

There are fundamental lessons to be learnt from how the HIV-AIDS pandemic was tackled over the years. Human rights defenders turned to life-saving treatment and persuaded courts and legislatures to compel nation-states to pay for it. This approach 'transformed the rights to discourse and strengthened all human rights' conceptual interdependence and indivisibility (Novogrodsky, 2009). UNHCR (2020) believes that asylum claims can be 'processed remotely where health restrictions prohibit face-to-face interviews in the case of refugees and asylum seekers. Other protection measures such as automatically extending registration cards or residency permits to enable refugees and asylum seekers to access health and other services, can also be adopted.'

### **Meaningful and comprehensive investments in healthcare facilities**

The COVID-19 pandemic struck when most healthcare systems across Africa were ill-equipped to handle its accompanying adverse effects. Although there have been high recovery rates in some instances, it cannot be denied that some preventable deaths have also been recorded. This calls for proper planning and increased investments in healthcare infrastructure and equipment such as hospital beds, isolation wards, personal protective equipment and intensive care units (HRW, 2020a; WHO, 2020a). Shortages of equipment and supplies undermine infection prevention and control efforts and affect healthcare professionals directly due to their heightened risk of exposure and infection (WHO, 2020a). In Zimbabwe, for example, nurses and doctors staged protests as they made loud cries about the lack of personal protective equipment at a time when the ruling elite abdicate their responsibility to invest in health services amidst their penchant for luxury cars, private jets, and lunatic sumptuousness (Zambara, 2020). More is also needed to boost staff morale by paying healthcare professionals reasonable salaries commensurate with their qualifications and experience. There is just no way demotivated personnel can be suitable for any healthcare system. Poorly equipped healthcare systems will continue to lose their personnel unless otherwise this is halted. Adequate investments in these systems will bring about the desired results in containing the spread of pandemics, both in the short and long run. As discussed earlier, public health services are underfunded in most states. Initiatives were taken in countries such as Tunisia and Morocco inspire hope and confidence in the ability of African states to respond effectively to the ravaging effects of COVID-19. It is also equally encouraging to note that the UN Secretary-General came up with the Africa Policy Brief on the effects of COVID-19. It not only called for an additional \$200 billion in financial support from the international community but also reiterated the need to realize more inclusive, equal, and sustainable societies and economies (Dersso, 2020).

## International cooperation and solidarity

Tackling pandemics such as COVID-19 from a human rights lens also calls for trust, solidarity and kindness. That the pandemic already has serious negative ramifications on high-income countries in the Global North is beyond argument. Thus, the situation can only be bleaker for low- and mid-income countries in the Global South, including Africa. Zambara (2020), for instance, observed that countries such as France, England, Italy, Spain, and the United States had failed to provide proper sanitization and adequate healthcare for the most vulnerable of their populations, especially the elderly and many more who succumbed to the pandemic in huge numbers, and yet these were fundamental human rights. International cooperation and solidarity are, *ipso facto*, morally imperative as the emerging countries will require both fiscal and technical assistance (WHO, 2020a). The May 2020 joint statement, initiated by the AU Assembly Bureau, is perhaps a quintessence of a call for global solidarity in mitigating human rights violations. The statement underscored the importance of human rights in any economic measures undertaken to reduce the effects of COVID-19 on the people. Thus, the emphasis was on meaningful investments in water, sanitation, health, social protection, sustainable infrastructures, and employment to leave no one behind (Dersso, 2020).

## Psychosocial support for victims of domestic and sexual violence

The impact of COVID-19 in all spheres of human existence is undeniable. The UN (2020b) noted that the pandemic was a physical health crisis and one that bore the potential to create a mental health crisis if appropriate and timely action were not taken. Nations have seen the psychological distress the pandemic has created in their people as they confront loss due to death, anxiety and fear of contracting the virus or infecting someone else with it and loss of income and independence required to care for self and family. Vulnerable groups, including frontline workers, women, children, adolescents, the elderly, and persons with pre-existing conditions, show signs of COVID-19-related psychological distress. Despite the severity and urgency of the situation, the provision and inclusion of psychosocial support in preventing, responding to and recovering from the pandemic is a cause for concern. Concerning this, the UN (2020b) has the following to say.

Because of the size of the problem, [most] mental health needs remain unaddressed. The response is hampered by the lack of investment in mental health promotion, prevention and care before the pandemic. This historic underinvestment in mental health needs to be redressed without delay to reduce immense suffering among hundreds of millions of people and mitigate long-term social and economic costs to society.

For instance, there has been a surge in sexual and domestic violence in African states since the COVID-19 pandemic struck. This has raised serious questions and concerns about safety at home and in the community in various localities. The provision of psychosocial support is often lacking in public emergencies as the focus is usually on saving lives. Nonetheless, the effects of the pandemic on women and girls have underscored the significance of providing psychological support and facilitating access to other support services during the pandemic (WHO, 2020a).

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There must be considerable investment in state-funded shelters to create safe spaces for victims of sexual and gender-based violence (Kagumire & Ouya, 2020). The arrest of soldiers implicated in raping women in Rwanda, as discussed earlier, is commendable as it demonstrates that women are cared for and will be protected from their abusers. In addition, in minimizing and mitigating the impact of COVID-19 on mental health, three key actions have been recommended by the UN (2020b): (1) apply a whole-of-society approach to promote, protect and care for mental health; (2) ensure widespread availability of emergency mental health and psychosocial support; and (3) support recovery from COVID-19 by building mental health services for the future (UN, 2020b)

## Further research

Finally, given that there is limited information on some of the socially disadvantaged groups during pandemics, it is recommended that there be knowledge generation and dissemination of inclusive data sets (UN, 2020a). Such research also needs to tackle the heightening inequalities and inequities brought to the fore by the pandemic. Many countries are reneging on their obligations to realize equity, equality, and sustainability. Instead, they are devoting their energies to pursuing retrogressive and oppressive policies, further disadvantaging vulnerable populations and exacerbating social and health outcomes (Sebastian, 2020).

## Conclusion

Considering the preceding discussion, the study arrived at two significant conclusions. First, COVID-19 presents opportunities and challenges for realizing and protecting and continuing critical discourse on human rights that nations must pay attention to, including those in Africa. As seen in Africa, COVID-19 has formed a cover under which multiple human rights violations flourish (Green, 2020; Sebastian, 2020; WHO, 2020a). There is a need for nation-states in Africa to activate and reform their morale and accountability mechanisms to combat COVID-19 through the creation, implementation and enforcement of socially relevant policies and legislations that address human rights infractions and respond to the effects of COVID-19 on the people. The pandemic will undoubtedly require these states to embrace innovation and practice fiscal prudence while fostering and sustaining multilateral partnerships in allies as the fight against COVID-19 extends beyond the African continent. With more discourse on human rights, awareness is created about responsibilities and moral obligations of nation-states, in partnership with civil society interest groups, the private sector and government while seeking to transform the structural inadequacies that promote and sustain human rights violations in an era such as this. Second, Africa must reflect on its previous responses to pandemics, become a leader in its own right, and develop evidence-based and culturally appropriate responses to the pandemic while fostering partnerships with allies in the Global North.

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# The Impacts of the COVID-19 Pandemic on Internally Displaced Persons (IDPs) in Nigeria's North-East Region

Sharkdam Wapmuk and Nufaisa Garba Ahmed

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## Abstract

Spurred by the unprecedented challenges posed by the COVID-19 pandemic and its spread to the northeast, an environment already devastated by the Boko Haram insurgency, the article looks at its impact on internally displaced persons (IDPs). It analyses data gathered from secondary sources and systematically juxtaposes these with reports and observations of developments in the IDP camps in the region. Major findings revealed that the COVID-19 pandemic had significant impacts on IDPs in the study area concerning their health, particularly by worsening the challenges of access to water, sanitation and hygiene, humanitarian relief, food security, and further escalating insecurity in the region. The findings further revealed that while the government's preventive measures helped to curb the rapid spread of the virus among the IDPs, the Boko Haram group and its affiliates exploited the lockdown to attack some communities and security forces in the north-east. In the process they killed and displaced more people than the COVID-19 pandemic in the region. This article concludes that the complex challenges presented by the COVID-19 pandemic as well as the already existing humanitarian crises require the synergy of efforts by federal, state, and local governments with the active support of humanitarian actors, particularly international organisations and non-governmental agencies working in the region to mitigate the impacts of COVID-19 on IDPs. It also underscores the urgent need for additional funding, allocation of land to build new camps to decongest the existing ones, and deployment of additional medical personnel and supplies to cater for the IDP camps in the north-eastern states of Nigeria.

## Keywords

Internally displaced persons (IDPs), insurgency, Boko Haram, COVID-19

## Introduction

The world is currently facing a health emergency as public attention and resources have been deployed to contain the scale, scope, velocity, and lethality of COVID-19 (SARS-CoV-2) of the novel coronavirus family. The disease has affected 213 countries worldwide, and 23,511,251 cases globally have been confirmed as of August 23, 2020 (Worldometer, 2020a). Hence, considering the scope and intensity of the outbreak, the World Health Organisation (WHO) officially declared the situation a 'pandemic' on March 11, 2020 (WHO, 2020a). As the virus spreads globally, healthcare systems, economies, security, livelihoods, among other important human development components, are being overwhelmed even in developed countries. As the pandemic continues to affect every facet of human lives with dire consequences, vulnerable populations, including Internally Displaced Persons (thereafter, IDPs) who remain victims of weak health systems and have limited access to services such as water, sanitation and hygiene, are prone to be most affected by the pandemic (Refugee International, 2020). In addition, over 70 million people have been forcibly displaced globally, thus making them susceptible to the attendant consequences of the COVID-19 emergency that can potentially worsen their living conditions (UNHCR, 2020a).

In Africa, the presence of about 25 million refugees, asylum seekers, and IDPs coupled with overcrowded settings, poor hygiene maintenance and limited quality health services in the camps where they are accommodated makes it difficult to shield these vulnerable groups against the impacts of the COVID-19 pandemic (Abebe & Abebe, 2020). More so, the region's experience with violent conflicts exacerbates the problem as most social and health infrastructures needed to contain the pandemic have been destroyed in the course of the war, hence, the slowdown affecting the efforts in finding credible solutions to IDP problems (Abebe & Abebe, 2020). Nigeria is not an exception for grave concerns associated with the emergence of the COVID-19 pandemic, especially being the first country in West Africa to experience the outbreak of the disease (Adepoju, 2020). Due to the complex humanitarian crisis and the significant number of IDPs in Nigeria's northeast due to the activities of the Boko Haram terrorist group operating in the region, the twin effects of conflict and pandemic cannot be underrated (Nextier Security, 2020). Though the north-east comprises Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe, the Bay States (Borno, Adamawa and Yobe) are worst hit by the Boko Haram insurgency since 1999.

The disease outbreak in Nigeria's north-east undoubtedly presents additional challenges in managing IDPs in the fragile region (IOM, 2020a). To further reaffirm the above assertion, the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) stated that with the emergence of COVID-19, the number of people in need of urgent assistance in north-east Nigeria rose from 7.9 million at the beginning of 2020 to 10.6 million by early July 2020 (UNOCHA, 2020a). However, in addition to facing eviction challenges, the IDPs remain subjected to stigmatisation, poverty, loss of livelihoods, human rights violations, poor access to decent living, and gender-based violence, among others (Global Protection Cluster, 2020).

Against this backdrop, it is evident that the emergence and spread of COVID-19 presented new challenges, dynamics, and trends in the fight against insurgency in the region and the management of the humanitarian crisis, especially that of the IDPs who are the most vulnerable. This article

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argues that the spread of the disease and the government's insufficient responses have exacerbated existing challenges and formed new ones for the IDPs in Nigeria's north-east. The article adopted a descriptive and qualitative approach to examine the pandemic, the resulting challenges, and efforts to contain both the pandemic and crisis in the north-east region of Nigeria. Data was gathered from secondary sources, including books, monographs, journal articles, government reports and websites of government institutions and international organisations. This was analysed through content analysis. The article, therefore, proceeds in four major parts. The first part provides a brief history of infectious diseases and examines the taxonomy of the novel coronavirus. The second part captures the emergence of the COVID-19 pandemic in Nigeria, its escalation, and various government control mechanisms. While the third part provides a detailed examination of the impact of the COVID-19 pandemic on IDPs in Nigeria, the fourth part is the conclusion.

### **An overview of infectious diseases and the nature of health governance**

Since time immemorial, infectious diseases have impacted the human population. Waves of infectious diseases such as the Bubonic Plague and the Black Death attacked and killed over 50% of Europeans during the Middle Ages, amidst others like smallpox that caused the death of many native populations in Europe (DiMaio *et al.*, 2020). Infectious diseases that affect humans, plants, and animals spread beyond geographical boundaries are called 'pandemics' (WHO, 2020b). Notable among these pandemics that occurred in the last century was the 1918 Influenza and the 1980s Acquired Immune Deficiency Syndrome (AIDS), which brought forth huge devastating impacts globally. The Influenza Pandemic of 1918 occurred after World War I, causing the death of tens of millions of people and displacing many others due to the non-availability of effective antibiotics and adequate health facilities for safely managing the effects and spread of this bacterial infection (Brown, 2020). The novel coronavirus (COVID-19) that hit the world in 2019 is a deadly respiratory infectious disease. The virus, which surfaced from Wuhan, China, is a member of the coronavirus family. The virus is believed to have emanated from animals and spread to humans. It manifests itself in the form of severe respiratory infection and can be transmitted from person to person. Since its emergence, most countries of the world have been affected, including the United States, United Kingdom, Germany, Italy and others, recording some of the highest cases in the world. The World Health Organization (WHO), the lead institution in global health management, officially declared the situation a 'pandemic' on March 11 2020 (WHO, 2020a).

Between 1945 and 1990, following multilateral institutions such as the WHO, global health emerged as a new movement towards the global administration of health. Thus, WHO assumed a dominant role in Global Health Governance (thereafter, GHG) by mobilising resources, technology, and goodwill from wealthy to poor nations to eliminate infectious diseases. Noteworthy is that GHG and its response are anchored on the actors' effectiveness in global health governance. By the 1990s, despite the emergence and involvement of other actors, it was no longer debatable that GHG was dominated by the WHO, both in terms of funding and strategic planning and guidance. Since then, WHO has continued to play an essential role in the global governance of health and disease, specifically by establishing, monitoring and enforcing international norms and

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standards and coordinating multiple actors toward common goals. Given the realities posed by global health pandemics, particularly in the context of the COVID-19 pandemic, global health governance has again taken centre stage in academic discourse. While multilateral solutions to the pandemic were explored, there was the tendency by states to look inwards and trade blame, as was the case between the USA and China. Beyond the global level of health governance, regional and national bodies have played varied roles in health governance in Africa. In the African context, several challenges have undermined effective health governance. There have been serious leadership and governance challenges that include weak public health leadership and management; inadequate health-related legislation and its enforcement; limited community participation in planning, management and monitoring of health services; weak inter-sectoral action; horizontal and vertical inequities in health systems; inefficiency in resource allocation and use; and weak national health information and research systems (Azevedo, 2017).

## **Understanding the emergence, escalation and control mechanism of COVID-19 in Nigeria**

Consequent to the outbreak of epidemic diseases across the globe, Nigeria, with an estimated population of over 200 million people, had experienced outbreaks of diseases in past years such as Lassa fever, Meningitis, Ebola and currently the COVID-19 pandemic, which have spread across different regions infecting different fractions of people in the country (NCDC, 2020a). Therefore, in order to adequately respond to the COVID-19 pandemic and mitigate future outbreaks, it is pertinent to understand the demographic profile of risk groups and transmission processes, trends and dynamics of recorded cases in Nigeria, Nigeria's testing capacity, and mechanism put in place for prevention and control of the further spread of the virus in the country. No doubt, this will provide helpful insights in understanding the impact on IDPs in the country.

### **Demographic profile of risk groups and transmission processes**

In Nigeria, the coronavirus has the potential of infecting all age groups that are either healthy or with a weak immune system, although data keeps changing as events unfold. However, according to a survey by the Nigerian Centre for Disease Control, from February 27 to March 27, 2020, a month after the first recorded case, they detected that:

Within the first 30 days, the NCDC observed that 70.0% of the individuals tested positive for COVID-19 were males, and 30.0% were females. Their ages ranged between 30 and 60 years. People aged 31-50 years were the most affected (39.0%). About 44.0% (101) of the cases were imported; some 41.0% (96) had incomplete epidemiological information—the sources of their infections were unknown. Thirty-five (15.0%) patients were known contacts of positive cases suggesting community transmission or cross-infection. Lagos State accounted for over 50% of the cases in Nigeria, followed by Abuja (20.3%) and Osun State (8.6%) (Amzat *et al.*, 2020, p. 2).

Nigeria recorded its first case on February 27, 2020, imported by an Italian man who had just returned to the country and tested positive for COVID-19. The aftermath of that imported case

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saw the meteoritic rise in the number of cases that got infected. As a result, the Presidential Task Force (PTF), inaugurated on March 09 2020, was saddled with the responsibility of controlling the spread of the virus buttressed that travellers coming from COVID-19 high-risk areas have the potential to infect and spread the virus, hence were banned from entering the country (Ihekweazu, 2020). Although the transmission mode of the COVID-19 virus is still being investigated, community transmission in Nigeria has risen due to non-compliance with infection prevention and control measures such as wearing a facemask, social distancing, regular hand washing, and staying at home (Sobowale, 2020).

## **Trends and dynamics of recorded cases in Nigeria**

Since Nigeria recorded its first case, the number of infected persons has continued to rise (NCDC, 2020b). The rise, including in north-east Nigeria, can be attributed to several factors. The first explanation is that despite proactive measures put in place by the Nigerian government, such as movement restrictions imposed by the federal and state governments and closure of borders, schools and places of worships, there still were reported incidents of movement by people who chose to go against the stay-at-home orders in search of food (*Vanguard Newspaper*, 2020). Secondly, at the initial outbreak of the pandemic in Nigeria, very few believed they could be susceptible to the virus due to top government officials' detection. Many held close to their hearts their belief in their faith and the so-called black man's resistance to diseases which adversely led to little or no regard for safety precautions (NOI Poll, 2020). Finally, the expansion in molecular testing capacity and house to house case search strategy has improved the detection of pressing cases of the virus that need urgent isolation (Buhari, 2020). The non-compliance to the stay-at-home orders for livelihood sustenance, the recalcitrant attitudes towards accepting the existence of the disease by some people and the IDPs resulted in unrestricted movement in and around the IDP camps exacerbating community transmission and spread of the virus in Nigeria.

Consequently, Nigeria is still grappling with an increasing number of cases and is exerting several efforts at both federal and state levels to contain the spread of the virus. Lagos, Ogun and the FCT were placed on lockdown at the federal level on March 30, 2020, being the hotspots of confirmed cases in the country (Campbell, 2020a). Also, the two principal international airports in Lagos and Abuja were closed amidst the imposition of travel restrictions for travellers coming in from China, Italy, Japan, Spain, US, and other high-risk places (Olaniyi, 2020). The suspension of railway services to decrease the spread of the virus also took effect from March 23, 2020, as local transmission continued to escalate nationwide (Adedeji, 2020). Other preventive measures adopted include social distancing, discouraging mass gatherings, use of nose masks, proper handwashing, use of alcohol-based hand sanitiser, ban on inter-state movements, closure of schools and markets, as advised by the Nigeria Center for Disease Control (NCDC, 2020b).

## **The impact of COVID-19 on IDPs in the north-east region**

In recent years, Nigeria has witnessed a dire complex emergency in the form of proliferation of humanitarian crisis as a result of the activities of violent non-state actors, which aggravated tensions and conflicts with its attendant consequences ranging from forced displacement, high



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rates of diseases to food crises (Olafioye, 2013). The menace has its roots in the outbreak of the Boko Haram insurgent group in Nigeria's north-east, responsible for innumerable attacks, killings, kidnappings, and destruction of properties in local communities across Nigerian states Chad, Cameroun and Niger (Hamid *et al.*, 2017). As a result, the region has witnessed the worst humanitarian crisis ever with millions of people in dire need of humanitarian assistance. The UNHCR (2015) estimated that about 1.8 million people have been internally displaced due to the crisis, and about 5.8 million people require urgent assistance for survival. Over 80% of the IDPs emerged from Borno state being the epicentre of the crisis, and about 60% live in host communities due to the hostilities meted to them by the insurgent group (OCHA, 2020c). The vulnerable population, particularly those displaced by a plaguing humanitarian crisis, are often victims of challenging socio-economic conditions and health disparities that affect their overall well-being. The IDMC recently submitted in its report that insurgency, violent conflicts as well as natural disasters and health challenges had triggered 33.4 million new internal displacements across 145 countries, reaching an all-time high number at the end of 2019, superseding the last highest recorded case in 2012 (IOM, 2020b).

Nigeria has been ranked the third most impacted country by the COVID-19 pandemic in Africa, with more than 10,000 confirmed cases and a death toll of about 300 as of June 2, 2020 (Agbibo, 2020). There has been mass public outcry and concerns about the potential attendant consequences of the pandemic on the already penurious and fragile north-eastern region. This is due to the deplorable living conditions of the 1.8 million IDPs living in congested camps in the Borno, Adamawa and Yobe, also known as BAY states, which according to the UNDP assessment experts, are prone to be affected most by the pandemic (UNDP, 2020a). The situation is further complicated due to the fractured healthcare system and facilities in the BAY states and other health services disrupted due to insurgent activities in the states. Hence, the immediate consequences of COVID-19 are impairing the low life expectancy of Nigerians, particularly the vulnerable, as articulated by the UNDP, such as "older people, women, young workers, migrant households, unprotected workers, people living in shelters, people who are homeless or in informal settlements, and people with underlying health issues" (UNDP, 2020b, p. 7). These stand a chance to be most affected by the pandemic.

In the north-east, Borno state was the first to record the COVID-19 pandemic on April 18, 2020. Since then, the virus continued to spread in the north-east states. For example, by July 23, 2020, Borno had 603 confirmed cases, 47 on admission and 521 discharged, and 35 deaths. Yobe had 64 confirmed cases, three on admission and 85 discharged, and nine deaths. Adamawa had a total of 115 cases, 21 on admission, 85 discharged and nine deaths. Even before the emergence of COVID-19 and its spread in Nigeria, 35% of health facilities in the affected states of Borno, Adamawa and Yobe were damaged as a result of Boko Haram and other conflicts in the region (UNDP, June 05, 2020). There have also been significant disruptions of vaccination campaigns and other essential health services for children and other vulnerable groups in inaccessible areas. In addition, funding has been a major challenge. It was reported that in 2019, the health sector working in the northeast received only 25% of its funding requests.

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North-east Nigeria, which has suffered a decade of insurgency and humanitarian crisis and more recently struck with a global health pandemic that subjects millions of people to delicate health conditions, has subjected the region to an overwhelming and complex burden beyond its full grasp. OCHA asserted that the outbreak of COVID-19 in the northeast has increased the number of people in need of humanitarian assistance from 7.9 million in January 2020 to 10.6 million by July 2020 (OCHA, 2020a). While government responses are imperative and proactive in containing the spread of COVID-19 in the northeast, the effects of the pandemic and its associated responses have created new challenges for the already complex crisis in the region, especially for the vulnerable IDPs.

## **COVID-19 and challenges of accessing healthcare**

The 2018 Health Access Quality (HAQ) index that measures the quality and accessibility of healthcare based on 32 causes of death that are preventable with effective medical care ranked Nigeria 187 out of 195 countries (Odubola, 2018). Consequently, containing the pandemic in a country like Nigeria with more than 200 million people would considerably overwhelm the health system in the country. As the virus spread across the country, there were initial fears of insufficient ventilators to cater for the needs of those affected. There were claims that at the onset of the pandemic in Nigeria, the country had only 169 ventilators in 16 out of the 36 states, thus indicating an average of only ten ventilators per state and only 13 molecular laboratories that carry out the test for the coronavirus for a whopping 200 million people (Daily Trust, April 2, 2020). With a better understanding of the virus, it became clear that not every infected person hospitalised needed a ventilator. As cases continued to accelerate daily, it became imperative for the government to cushion this challenge. The NCDC organised staff training on molecular diagnostic capacities in conjunction with the Africa Centre for Disease Control in Dakar. The NCDC established an Emergency Operation Centre and an array of molecular diagnostic laboratories to further complement this effort to improve COVID-19 diagnosing capacity across Nigeria. The NCDC has also collaborated with state governments and private sector partners to significantly ensure efficient diagnosis processes and case finding for potential asymptomatic transmitters (Alagboso & Abubakar, 2020). This initiative helped in building the COVID-19 diagnosing capacity of beneficiaries of the training in Nigeria.

Another major health impact of COVID-19 on IDPs is that it further aggravated health issues due to the congested nature of camps where they reside. The prescribed global preventive measures for the virus would be somewhat challenging to implement, especially in these overcrowded camps. Given the clarity in the disease transmission of the virus, the defence mechanism against the spread of the virus has been the encouragement of social distancing and self-isolation as a means to minimise contact between persons (WHO, 2020d). However, the reality of IDP camps in Nigeria makes the enforcement of these measures near impossible given the overcrowded nature of the camps that houses multiple times the required number, hence unfit for healthy living. Consequently, according to the Borno State COVID-19 Preparedness and Response Plan survey, almost all the LGAs where the overcrowded camps are located are 'high risk' places (UNDP, 2020b). To further reaffirm this claim, DMS/CCM assessed IDP camps in the BAY States and also asserted that one in four camps where about 430,000 IDPs reside are highly overcrowded

with per capita space of less than 15m<sup>2</sup>, hence the potential risk of spreading the virus among persons is relatively high.

Similarly, in addition to space constraints, deficient access to safe and clean water and sanitation further inhibits the successful implementation of preventive measures against vulnerable communities. In recent years, the outbreak of deadly diseases in the region such as cholera, malaria and measles has subjected IDPs to benign medical conditions- for example, in 2017, an outbreak of cholera across IDP camps in Nigeria resulted in about 4,800 cases and 61 deaths (Hamid *et al.*, 2017). Accordingly, data by the International Organization for Migration presents that globally, the outbreak of COVID-19 has inhibited the administration of immunisations against polio and other diseases, hence exposing the lives of an estimated 80 million children under the age of 1 to many risks, and their potential to infect the larger population remains high (IOM, 2020a). In consonance, the WHO asserted that as COVID-19 continues to loom, there exists a possibility of reaching a transmission rate of 3.3% in the absence of strict compliance to prescribed mitigation measures. In the event of an outbreak in camps termed as 'highly congested' (beyond the prescribed maximum capacity), there is a possibility of about 400,000 IDPs being potentially infected (WHO, 2020e).

The first line of action by the Nigerian health sector in responding to the challenges in IDP camps is leveraging on the existing multi-sectoral efforts that were initially put in place to address the humanitarian crisis in the northeast. A Joint Support Framework was adopted, which incorporated governmental authorities, non-governmental agencies, donor agencies, UN agencies, and associated partners in devising a blueprint to prevent the spread of the pandemic to IDP camps and camp-like settings. A rapid response plan was birthed by the health sector in collaboration with Camp Coordination and Camp Management (CCCM) sector, Water Sanitation and Hygiene (WASH) sector, and the Shelter sector to counter these challenges. The collaboration positively enabled the planned decongestion strategy that targeted 400,000 individuals living in highly congested camps in the BAY states (Amzat *et al.*, 2020). With this decongestion of camps and appropriate shelter provision to meet needs, human-to-human transmission can be significantly reduced. Also, Infection Prevention and Control (IPC) practices were strengthened in IDP camps and communities in the BAY states between May and July 2020 to ensure timely treatment of COVID-19 cases and prevent further transmission. Health staff at the forefront of this task were trained for early detection of IPC and provided with sufficient tools, including Personal Protective Equipment (PPE) and more WASH services/hand hygiene stations (Abdullahi, 2020).

## **Constrained access to humanitarian relief**

The outbreak of COVID-19 in the BAY states with about seven million people that depend on humanitarian assistance for survival has inadvertently affected the capacity of humanitarian aid givers to reach out to communities in need. This is due to the restrictions of movement in and out of the states to minimise human contacts that could scale up transmission rates of the virus. This disrupted effective supply chains and caused a delay in the delivery of aid and relief materials. For example, Borno state enforced a total lockdown and imposed restrictions on intra-state movements, which affected the movement of fundamental service providers such as

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humanitarian personnel, food and water vendors, cargo movements, among others (OCHA, 2020c). Consequently, members of the humanitarian community in the state were granted only 103 exemption passes, totaling less than 5% of the requested number and just about one-fifth of the total number issued by the state government, despite advocating to be exempted from the lockdown directives due to the critical nature of their services (WHO, 2020e). Similarly, the abduction and execution by terrorists of aid workers who provide humanitarian services to the needy had become an everyday nightmare in the region, especially during the pandemic crisis when the terrorists took advantage of the situation to wreak havoc and extract huge ransom from kidnapped humanitarian aid workers. Consequently, humanitarian organisations were compelled to limit their services, especially in delivering foodstuffs and medical services to IDPs in the region (OCHA, 2020d).

Nevertheless, in collaboration with other partners such as the WHO, the health sector pulled in efforts to coordinate humanitarian responses to COVID-19 in the north-east. The interventions were aimed at providing support and monitoring ongoing humanitarian response in host communities and hard-to-reach areas. This ensures that critical services are delivered while ensuring that livelihood protection initiatives (social safety net) are adequately dispersed in different areas. Thus, sector partners have continued to deliver food assistance in the respective locations while maintaining a coordinated approach to managing the COVID-19 emergency demands on livelihoods and food supply (WHO, 2020d).

## **Information Flow and Public Acceptance of the Pandemic**

Credible knowledge and authoritative information are requirements to contain the spread of false news about the COVID-19 pandemic and disseminate details of prevention measures. However, the poorly educated among the IDPs might not assimilate and comprehend such information even when it reaches them. Despite the meteoric rise of the pandemic across the north-east, the spread of fake news and poor communication channels subjected many to believing the pandemic is a ruse that is politically motivated by the state governments to attract international aid and funding (Christopher, 2020). A disregard of safety measures for protecting oneself against COVID-19 might be counter-productive to efforts to curb the spread of the virus. Also, some might consider the instructions for preventive measures as something contrary to their cultural beliefs. For example, measures such as isolating a patient showing symptoms of the virus or not being informed of the death of their relative who has been hospitalised are being viewed by some traditionalists as pro-West (Relief Web, 2020).

To ensure effective flow of information and communication to the general public, the NCDC Connect Centre established the Event-Based Surveillance Network saddled with managing the NCDC toll-free-line and social media platforms for dissemination of information (NDC, 2021). Similarly, in order to create more awareness and enlighten the general public about the disease and how best to prevent and guard against it, the NCDC, in collaboration with other organisations, has produced and circulated vital multimedia content that will enhance a better understanding of the pandemic (NDC, 2021). These contents vary from videos, infographics and

audiovisuals to audio jingles that target different demographics in different languages. Beyond these productions, the NCDC has leveraged technology and used social media podiums such as live online sessions, WhatsApp messages and the NCDC website to circulate public health messages around the country and beyond (NDC, 2021). Most importantly, the NCDC has deployed resources to train media officials and journalists on reporting details and news on COVID-19 (Alagboso & Abubakar, 2020).

## **Disruption to livelihoods and food supply chains**

The 2019 Global Report on Food Crises estimates that about 113 million people are food insecure in 53 countries. “The COVID-19 pandemic risks further escalate these figures, with likely significant rises in humanitarian needs and food insecurity as a consequence of the pandemic itself and some of the containment efforts” (FAO, 2019). Particularly in Nigeria’s north-east, the outbreak of COVID-19 has influenced a reduction in production efficiency and distribution of agricultural products and intra- and inter-regional trade in agriculture (FAO, 2020b). The enforcement of total lockdown and closure of markets for perishable goods and retail stores in a state like Borno from April to May severely impacted the region’s food supply chains. Farming communities were prevented from accessing lands for food cultivation, and other livelihoods support mechanisms due to an increase in insurgent attacks in May (FAO, 2020b). As a consequence of low productivity in farmers produce, people that are already vulnerable continue to depend on humanitarian aid for life continuity as all monetary inflows were regulated. IDPs already susceptible to poor earnings and living conditions have been confronted with newer risks due to timely, proactive and protection measures to support survival and livelihoods (FOA, 2020a).

It is crucial to state that the Nigerian economy has been experiencing a crisis before the pandemic due to a decline in per capita GDP levels. This was exacerbated by falling crude oil costs in the international oil market, thus increasing the vulnerabilities in Nigeria’s economy. Of great concern is that the informal sector largely dominates the Nigerian economy and is presumed to be vulnerable to external shocks such as the outbreak of the COVID-19 pandemic. Considering the nature of income generation in the sector, which is premised upon daily whims of the market, the negative economic impacts of the pandemic hinder the groups’ efforts in meeting their immediate needs, which rely on daily physical interactions with customers (Oruonye *et al.*, 2020). In order to lessen the economic impacts of the pandemic caused by the emergency shutdown of businesses and means to livelihoods as a result of the lockdown, the government announced that it would distribute palliatives in the form of food items and ‘conditional cash transfer’ to poor and vulnerable households registered in the National Social Register (NRS) (SayNo Campaign, April 15, 2020). The initiative was estimated to cover 3.6 million citizens who depend on daily income and those with disabilities whose means of livelihoods have been halted. However, it reported that only a fraction of the poor benefited from this package as Nigeria lacks an efficient national information management system for swift payments. More so, an estimated 87 million Nigerians live on less than US\$1.90 a day which makes the government’s efforts to reach its target futile (Dauda *et al.*, 2020).

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Similarly, the Emergency Economic Stimulus Bill 2020 was passed on March 24, 2020, by the House of Representatives to provide support to businesses registered under the Companies and Allied Matters Act by providing 50% tax rebates. While the bill is a move to provide relief to formal businesses amidst the impacts of the pandemic to commerce, the informal sector, which contributes about 65% of the country's GDP and 90% of the workforce, is mostly characterised by unregistered businesses that will disqualify them from accessing this benefit (Odiase, 2020). Consequently, such situations could birth violence in attempts to access limited resources amidst other negative coping mechanisms to sustain a living, especially for displaced people.

### **Escalation of insurgent attacks and civil unrest**

Public health guidelines, as outlined by the WHO and adopted by Nigeria's Ministry of Health, stipulate public adherence to directives and protocols that incorporate a multi-sector response that includes the roles of security agencies in ensuring compliance with the law and order (WHO, 2020e). The necessary lockdown and restrictions of inter-state movements in the BAY states have put security personnel at the forefront of enforcing strict obedience to directives. Numerous roadblocks and checkpoints were positioned on highways and within the BAY states, with the police, the military, the Federal Road Safety Corps (FRSC) and Nigeria Security and Civil Defense Corps (NSCDC) taking the lead to enforce compliance (Iweze, 2020). This move became crucial to minimise community and cross-location transmission of the disease (Iweze, 2020). The dynamics and readjustments in operational priorities and the military preoccupation in enforcing lockdown directives as restrictive measures to contain the spread of COVID-19 in the northeast has created an ambience for violent non-state armed groups, in particular, Boko Haram and its affiliates, to take advantage and increase their operations in the region (Thisday News, June 6, 2020). This was made possible by the redeployment of the military and the overstretched nature of their disposition in dealing with counter-insurgency operations, on the one hand, and the imposition of lockdown, on the other hand. The situation created gaps that gave space for terrorists to operate in areas where the military was preoccupied with internal security engagements.

Furthermore, the government's shift of focus from counter-insurgency operations to restrictive measures gave the sect an edge to organise indiscriminate abductions and form new gangs of fighters. New trends of offensive attacks on military forces and civilians have swollen up, as even military commanders have been ambushed and killed during military operations to ensure compliance with lockdown directives (Thisday News, June 06, 2020). In a major operation carried out by Boko Haram in Borno state on March 21, 2020, a military convoy carrying military officers and other security personnel were ambushed along the Alagarno forest leading to the death of over 50 soldiers (Campbell, 2020b). Likewise, the local government areas of Gubio, Nganzai and Monguno were attacked afterwards, with several people killed and about 120,000 people displaced and forced to seek shelter in neighbouring communities (Thisday News, 2020).

Additionally, the rise in the number of infected persons in the BAY states has doubled the task of security personnel who are now saddled with the responsibility of not only combating insurgency

but ensuring the safe delivery of medical equipment to the areas in need as well as safeguarding and protecting IDPs in camps among other vulnerable groups in the society. Equally, it is extremely difficult for military personnel in the field to practice some of the prescribed global preventive measures like social distancing due to the nature of conducting operations and their associations with vulnerable populations, among other vices (Iweze, 2020). This is because military operations, by their very nature, involve engagements with the local populace and other social dynamics that will involve close cooperation and collaboration, thereby compromising the spirit of social distancing.

## **Secondary displacements and infringement on human rights**

The potential of the COVID-19 pandemic to exacerbate existing conflicts and vulnerabilities vis-a-vis new displacement is very high given the fragile governance in regions experiencing outbreaks of violence. Factors like congestions in IDP camps and poor hygiene, among others, can hamper efforts to control and mitigate the spread of the virus, which in turn can spark more frustration, aggression and further conflict (ICG, 2020). The porous nature of Nigeria's land borders and unmanned forest reserves have enabled the swift transfer of Small Arms and Light Weapons (SALWs) and cross border movement of people, including the Fulani herdsmen across West African countries whose movement also threatens the indigenous Fulani herdsmen in Nigeria. This has made it difficult for total territorial control and guaranteeing the safety and security of citizens. Considering the first index case of COVID-19 imported by an Italian traveller, it became imperative for the Nigerian government to shut down its air and land borders on March 23, 2020 (Ilesanmi & Afolabi, 2020). This move was made to deflate the potential number of foreign cases and limit the movement of itinerant persons who can become veritable transmission agents (Ilesanmi & Afolabi, 2020). In this regard, there has been a reduction in the number of people that troop into IDP camps since January 2020, owing to the restrictive measures enforced to control the spread of the pandemic, especially in April when the total lockdown was enforced to restrict inter-state and border movements within the northeastern region (Ilesanmi & Afolabi, 2020). However, despite border closures, IDPs still made attempts at cross-border movement from Cameroon, Niger, and Chad due to attacks by insurgents or military operations.

While the closure of borders as a COVID-19 preventive measure is a proactive effort by the government to contain the looming effects of the pandemic, it has also hitherto affected the right to return and right to seek asylum for most displaced people as IDPs face mandatory detention in borders for days before admission into the territory after the observance of COVID-19 control protocols. More so, the situation continues to cause secondary, and multiple displacements of populations as accessing camps and host communities searching for safety has appeared cumbersome (OSIWA, 2020). In addition to these prevailing factors, the lockdown and prohibition of movements out of camps in LGAs such as Jere and Konduga have made accessing water in host communities virtually impossible in northeastern Nigeria. (UNDP, 2020b).

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## Conclusion

The article examined the emergence, spread and impact of the novel coronavirus (COVID-19) pandemic on Nigeria's north-eastern states that have been devastated by the Boko Haram insurgency. The virus further exacerbates the already existing humanitarian challenges in IDP camps. While noting the proactive measures taken by the Nigerian government, most of which helped to reduce the massive spread of the virus, the article further argued that the COVID-19 pandemic and government responses have led to the emergence of new challenges in the management of IDPs in the northeast region. Since the intensification of the Boko Haram insurgency in 2009, Nigeria's north-east has not known peace. The terrorist group has been responsible for innumerable attacks, killings, kidnappings, and destruction of properties in local communities across the Nigerian states, Chad, Cameroun and Niger and the displacement of thousands of people, particularly in the BAY states. The Boko Haram crisis has created a huge humanitarian crisis and the collapse of the health sector even before the emergence of the COVID-19 pandemic in Nigeria. The article revealed that the COVID-19 had major impacts on IDPs in health, humanitarian relief, food security and escalation of insecurity in the region. Findings revealed that Boko Haram and its affiliates exploited the lockdown, which was one of the measures taken to curb further spread of the virus, to attack some communities and security forces, killing more people than COVID-19 did in the north-east.

The new challenges presented by the COVID-19 pandemic and responses require an urgent rethinking of the security, humanitarian and health challenges and the recalibration of measures to solve the northeast crises. This has become even more critical against the backdrop of possible reduction of global funding of humanitarian activities at global and national levels. There is no doubt that the United Nations (UN) remains the world's multilateral organisation that connects all the other humanitarian organisations. The funding of the UN comes from assessed contributions of Member States, whose variation is determined by a complex formula that factors in gross national income and population. Already, the UNDP has reported that the outbreak of the COVID-19 pandemic has further exacerbated the humanitarian situation in the northeast, thus requiring urgent attention. The recent COVID-19 pandemic has negatively impacted member states' economies with significant implications for the funding of the UN and its agencies. This is further complicated by competition, power politics and disagreement between the US and China, leaving the funding unreleased for the WHO (Wong, 2019). The US is the largest UN donor, contributing roughly \$10 billion in 2018 (Shendruk, Hillard & Roy, 2020). In 2020, President Donald Trump announced the US intention to halt funding to the WHO (Hoffman & Vazquez, 2020). This could also affect the UNHCR in terms of drop-in funds and, hence, impact the livelihood of displaced populations.

Given the new challenges posed by the COVID-19 pandemic, which add to the existing insecurity and humanitarian crisis inflicted by the Boko Haram insurgency, humanitarian activities in Nigeria's north-east will require targeted and coordinated response to the web of crisis arising from terrorism and COVID-19 in the region. The importance of strengthening security, particularly the protection of people and humanitarian workers in remote rural communities,



cannot be over-emphasised. This has become critical, especially against the backdrop of the recent escalation of humanitarian challenges due to killings and displacements of people in some rural communities in Borno state while the state was under COVID-19 lockdown. Secondly, there is an urgent need for additional funding and allocation of land to build new camps to decongest the existing ones and additional medical personnel and supplies to cater for the IDP camps in the BAY states. This will require deeper government involvement at the federal, state, and local levels to ensure the availability and adequacy of humanitarian and medical supplies and facilitate their delivery to urban and rural IDP camps in the northeast. It also requires active engagement and improved coordination of humanitarian efforts by actively engaging humanitarian actors, particularly international organisations and civil society actors currently supporting the Nigerian government, in addressing the humanitarian challenges in the north-east.

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# Contending Narratives on the COVID-19 Pandemic and Public Authority Governance in Nigeria

Nzube A. Chukwuma

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## Abstract

This study interrogates the contending narratives in the fight against COVID-19 and public authority governance in Nigeria. Since the outbreak of the Coronavirus in 2019 in Wuhan, China, countries worldwide have been battling against its exponential rise. In Nigeria, with many reported coronavirus cases, the government had responded by budgeting millions of dollars to curtail the spread of the disease and procure vaccines. However, Nigerians have questioned the responses of the public authority in the governance affairs of Coronavirus. Why is this the case? Literature on the COVID-19 pandemic in Nigeria has pointed out corruption, mismanagement, human rights abuses, poor planning, and the decay in the health sectors. With David Easton System Theory, the study generated data through documentary methods and analysed them using the narrative analytical technique. The article observes that while the COVID-19 pandemic has resurfaced the contending trajectories in the health, political and economic discourses, public authorities' governance has continued to witness cycles of legitimacy crises. The study suggests that no amount of audio pledged by the government can remedy the Nigerian trajectories without addressing the public authorities' fallout with the people and strong legislations against government officials' foreign medical tourism.

## Keywords

COVID-19, Nigeria, legitimacy crises, systems theory

## Introduction

The year 2020 began with the Coronavirus pandemic that initially started in December 2019. From being an epidemic circle in China, it suddenly exploded to become a pandemic across countries in Asia, Europe, the Americas, Australia, and Africa. In these continents and countries, government health and financial policy responses have been remarkably different, particularly in tracking coronavirus cases. While the government responses differ across the world, citizens, on

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the other hand, have reacted and responded differently. The two scenarios generated questions and debates on governmental approaches of employing democratic measures, on the one hand, and authoritarian means, on the other, to handle widespread cases better than others. In a survey conducted by The Winton Centre for Risk and Evidence Communication on 700 respondents from selected countries in Europe, Australia, and America to assess governments' response and reactions to the risk of Coronavirus, it was found out there were striking differences and similarities (Freeman, 2020). While the differences further generate debates on the appropriate government decision and citizens' responses, there are constant fears and anxieties across the world on the number of deaths and new cases per day and the economic toll of the COVID-19 pandemic.

In that vein, the severity of deaths without limits outside China, the original epicentre, is alarming. According to the World Health Organisation (WHO), an epidemiological update indicates that from January 2020 to 17 February 2021, the pandemic outbreak has claimed 2,394,323 lives and "caused" a cumulative of over 108,484,802 confirmed cases globally. At the continental and regional levels, America is the worst hit with 48,401,821; Europe 36,573,613, South-East Asia 13,215,160, Eastern Mediterranean 6,023,779, Africa 2,732,136, and Western Pacific 1,537,548 (WHO, 2021).

On the other hand, the global economic prospect of COVID-19 has remained dramatic. In its flagship World Economic Outlook, the International Monetary Fund (IMF) estimated the pandemic's final economic toll at \$28 trillion (Elliott, 2020). While the economic shock has worsened compared to the Great Depression of the 1930s, the recovery and performances in developed and developing countries' macroeconomic and microeconomic indicators have remained low. However, Jones, Palumbo & Brown (2021) argued that except for China, with a registered increase in the economic growth of 2.3%, other national economies and businesses count the costs as the worldwide government struggles with a new variant of Coronavirus and new measures to tackle its spread.

Beyond these figures of death, new cases and the economic toll, public authorities' overwhelming governance response in Africa has been a subject of comparison with the developed countries. In Nigeria, there has been a comparison between Nigeria and other African countries in their reactions. While comparison with developed economies may appear contentious, the key to governing the problem is a matter of decision-making in the whole society. Peters and Pierre (2016), in their joint study, contend that this decision-making is a functionalist approach that typically includes decision-making as a core function of government. So, in both developed and developing economies, governance is about final action in a societal process where governing institutions set priorities for society and impose regulation and other authoritative measures to involve the community in pursuing those collective priorities (Peters & Pierre, 2016). In line with this, Pernia (2017) argued that Easton's political system's essence is the political system's roles in decision-making on behalf of society and the performing actions that implement the decisions and allocate scarce resources.

Decision-making and other authoritative measures in Nigeria have generated controversies.



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However, the government's goal is to adopt as many combinations of containment decision-making strategies as possible. In Africa and particularly in Nigeria, the measures are necessary considering the health report by the African Centre for Strategic Studies (ACSS) of many African countries such as Uganda, Nigeria, Senegal, and South Africa. The ACSS reported that these countries have existing fragile health systems, current disease burden, and overcrowded informal sectors (ACSS, 2020a). Similarly, in the ACSS composite compiled lists, the study identified collapse in the public health system, rising conflict; forced displacement; and lack of government transparency as some of the risk indicators of COVID-19. The report also categorised Nigeria, Sudan, DRC and South Sudan as multi-layered highest risk profile countries to express high impacts of COVID-19 using the risk indicators (ACSS, 2020b). This appears to be a justification for a total of 102 new legislative actions and executive orders by governments across 45 countries in Africa. These legislative actions were codified to address the outbreak of COVID-19 and save the collapsing health sectors in these countries (International Centre for Not-for-Profit Law (ICNL 2020).

In Nigeria, the government strategies to manage the outbreak of the virus began with establishing the Presidential Task Forces (PTF) on COVID-19 for the whole country. Nigeria confirmed its first case of the Coronavirus in Nigeria, Lagos, on Friday, 28 January 2020. The patient was an Italian contractor who arrived in Nigeria from Milan. It was announced by the Nigeria Centre for Disease Control (NCDC) which was established in 2011 to address public health emergencies and enhance Nigeria's readiness and response to any communicable and non-communicable diseases. The confirmation of the first patient of Coronavirus led to the activation, through the NCDC, of the Nigerian Coronavirus Emergency Operation Centre generally called the Public Health Emergency Operation Centres (PHEOCs). Before the activation, PHEOCs have been established in 23 out of the 36 states of Nigeria to detect, prevent, monitor and respond to infectious diseases outbreak.

The Nigerian government inaugurated the PTF on 17 March 2020 to function for six months and with a possible extension to strengthen containment strategies. The Secretary to the Federation (SGF), Boss Mustapha, headed the task force while Dr Sani Aliyu became the National Coordinator. Other task force members included experts in health and health-related disciplines, ministries from the Aviation, Education, Information and Culture, Environment and Humanitarian Affairs, and Disease Management as well as Director-Generals of the Department of State Security (DSS), the Nigeria Centre for Disease Control, and the Nigerian representative of the World Health Organisation (WHO). As a national response team, the task force synergises with all the states and local governments, private sectors, faith-based establishments, and civil societies to create adequate and maximum awareness among the Nigerian populace. It also seeks health and financial assistance from donor agencies such as WHO, IMF, and World Bank. Further, it advises Nigeria's federal government on containment measures such as lockdown and other related health policy.

However, while the NCDC measures and activities by the task force yielded success stories in containing the spread of Coronavirus, renewed contending narratives emerged from Nigeria's public authority decision-making on COVID-19. At large, the controversies overshadowed visible attempts made by the government in the handling of the outbreak both at the national and

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state/local levels. The controversies are based on two issues. The first is that literature on public authority governance has revolved around so many years of corruption and bad governance in all government sectors. So, during the COVID-19, the literature on bad governance resurrected, including human abuses. The second is that during other national health emergencies like the Ebola and Lassa Fever, the government has failed despite repeated promises to increase funding and revive the health sector. At each end of the controversies, neither the increased funding nor revamp of the health system took place.

Therefore, the article interrogates why the literature persisted to generate contending narratives that have resurfaced in the middle of efforts made by public authorities in Nigeria to fight COVID-19. The article is divided into four parts. The first adopts a theoretical framework as a guide to the explanation of the literature on governance in Nigeria. It will aid in the understanding of public authority's persistent failures in Nigeria. The next part highlights the Nigeria epidemiological report card and NCDC's activities to protect Nigerians against the Coronavirus. The third part identifies health, political, and economic issues classified as the substantive COVID-19 contending narratives in Nigeria. The fourth part forms the conclusion and recommendations. In this study, public authority governance implies responses by relevant authorities at the federal, state, and local governments and agencies in Nigeria to curtail the spread of Coronavirus.

## Theoretical perspective

One framework of interpreting public authority governance crises in managing the Nigerian political system is through the lens of Easton's systems theory analysis. David Easton first conceived the adaptation of systems theory to political science in his book, *The Political System*, in 1953. In the book, Easton defined politics as the "authoritative allocation of value". In that context, Easton identifies the primary study of politics, which is concerned with understanding how authoritative decisions are made and executed for a society (Easton, 1957). Activating the meaning of authoritative allocation of value, Gabriel (2017) argued that Easton has successfully distinguished between authoritative action that is "political" permitted by authoritative agents or public authority in the name of the whole society from other private activity that is "para-political" and related to other societal subsystem interaction. Implicit in Gabriel's "political" explanation is that the political system is different from religion, social, economic, and cultural subsystems because it has its definite boundaries that are in constant interactions in the decision making for society (Stewart, 1981)

In that vein, Evans (2014) argued that two points from the 1953 book seem relevant in discussing Easton's system theory. The first is the derivation of the meaning of "political", and the second is the understanding of "political system". As regards the first, political refers to concerns with all activities that significantly influence the making and execution of authoritative policy for society. So, authoritative policy by the political authority is binding and enforceable through legitimacy. However, authority is the legitimate exercise of imperative control on all society members (Gabriel, 2017). Pertinent to the second, a political system is a set of interactions abstracted from the totality of social behaviour through which values are authoritatively allocated for a society. In

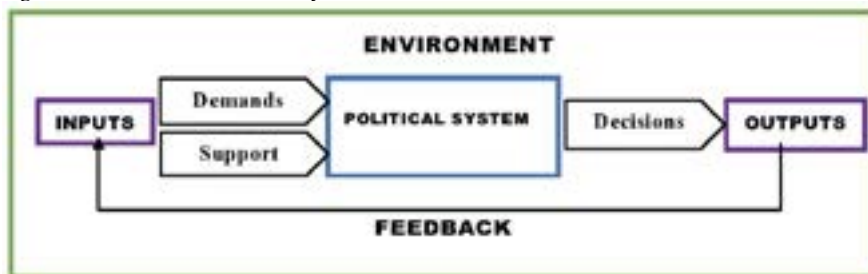
that context, Easton rejected the traditionally accepted units of analysis for a society known as the state and power and instead chose the system as the central unit of analysis (Evans, 2014).

Therefore, David Easton conceived four properties of a systems theory (see figure 1). The first property as *a system* is the basic unit of analysis. Its interaction in any society creates authoritative powers to make and implement decisions across the political system. The system integrates with many intra- and inter-systems for the benefits of cooperation and authoritative decisions. Easton's substantial departure hinges on the idea that the explanation of political life has neglected an anthropological study of the "fact" regarding political life outside the states and power over the centuries.

Consequently, all historical societies are structured in forms of political processes or interaction and social behaviour that requires minimal use of state and power. Because the authoritative allocation of values to exercise domination is by virtue of voluntary support or by legitimisation, a strategic process that entails justifications and attempts to influence public opinion (Wæraas 2009). In that context, the exercise of power in the Weberian concept is too irrelevant because the legitimisation principles ensured public authority endorsement with support from the general public when the subject perceives the system in an environment worthy of voluntary compliance (Wæraas, 2009).

The next property by Easton is the *environment* of a political system. According to Evans (2004), there are two types of environment in a political system. The first is a domestic environment surrounded by intra-societal interactions such as tax, justice, security, and economic well-being. The second is an international environment surrounded by extra-societal interactions that prevail in international politics. The environment is where every unit of the action takes place. Any conflict or change that emerged from this environment can be a determinant factor in any political system's functional or dysfunctional stage. In other words, every political system must encounter stressful disturbance from the environment. Nevertheless, the system must cope with the disturbances from the environment that are sometimes dangerous to the system survival. Therefore, in the boundaries or environment, the inputs demand or support and outputs or decisions are only valid within the political system units known as the environment.

Figure 1. David Easton's Political System Model.



Source: Pernia (2017)

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The third property is the *inputs and outputs*. Maintaining the essential variables between the system and environment, Easton created two components: the *inputs* and the *outputs*. These two components underlie the existence and structure of interaction in the political system. The inputs and outputs relationship are to ensure system maintenance and persistence. For the inputs, it has demands and supports from the internal source or environment. Simultaneously, the outputs imply the decision from political authority or response from the internal sources' demands and supports. Generally, the political system inputs interact with the outputs, which are the authoritative political decisions or policy. In that way, government decision-making aims to balance the inputs of demands or supports from internal sources.

In most cases, the government responds to internal sources from domestic environments or people, political class, civil societies, and oppositions. On the other hand, international environment sources like international organisations—the IMF, World Bank and European Union or countries such as China and the United States receive authoritative decisions from Nigeria's political system. Nonetheless, the type of decisions in the environment is dependent on the nature of the political system—democracy, dictatorship or monarchy. The final property considered by Easton is the *feedback loop*. The *feedback loop* is a never-ending essential circle of communication and information chain of interaction that is either positive or negative in the political system's environment. So, when a specific policy as output interacts with its environment to generate an outcome or inputs, this new outcome, following interactions with the environment, produces new supports either favourable or dishonourable to the policy. The supports, as a feedback mechanism within the political system, lead to new demands and supports.

Drawing from Easton's four significant broader properties, we explain the underlying questioning of the public authority's decision-making in the governance of coronavirus affairs in Nigeria. By so doing, we understood what had dominated the public discourses in Nigeria since the first case of the virus in the country. The PTF is expected to coordinate Nigeria's National COVID-19 pandemic Multi-Sectoral Response Plan (PMSRP). The PMSRP's overall goal is to stop further transmission of the Coronavirus within Nigeria and ensure effective and safe treatment centres to manage outbreaks. Furthermore, the PMSRP revolved around four administrative policy purposes and objectives. The first is to provide a coordinated and effective national and sub-national response to the COVID-19 pandemic. The second is to reduce COVID-19 related morbidity and mortality while the third is to mitigate pandemic-related impacts on critical social, economic and health infrastructure and systems. The fourth is to facilitate post-pandemic recovery and rehabilitation operations (PMSRP 2020).

These analogies of Easton's properties and the PMSRP objectives are significant in managing the COVID-19 pandemic and public authority governance in Nigeria. As a political system, Nigeria has institutions of government responsible for managing and piloting the affairs of the country, known as the legislature, the executive, and the judiciary. With distinct spheres of responsibilities in these institutions, their existence and functions are for the interest of all citizens. Therefore, the authoritative allocation of values during the COVID-19 pandemic should be around the institutions, policy formulation, enforcement and interpretation through correspondence with

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the people. Thus, the synergies of interaction in governance policies of COVID-19 that emanate from the public authorities and its institutions should always serve and reflect inputs from the environment. Contrarily, the absence of synergies of functionalities and properties within the system can lead to crises and a dysfunctional political system. If the properties function properly, the political system will be stable and achieve the required goals.

In Nigeria, debates and controversies have revolved around the crisis of functionalities and synergies of interactions. The Nigeria National COVID-19 Pandemic Multi-Sectoral Response Plan (PMSRP) and decisions by the public authority have created dysfunctional interactions in the country. The outputs from the government and the inputs by the citizens and other non-governmental establishments such as private schools and faith-based institutions appear to be disconnected. This disparity of response between what the people want and what the government offers has continually been a nightmare in Nigeria. In protest against government outputs, Nigerian's compliance with lockdown and prevention measures is at a low ebb. Although citizens' responses globally have been problematic, Nigeria's poor compliance with public authority PMSRP guidelines has been characterised by two factors.

The first factor is the weakness in the Nigeria national plan for COVID-19. The PMSRP policy responses taken together are not commensurate with the magnitude of the health, economic, and political problems COVID-19 has generated in the country. In that case, the policy is weak and appears suspicious to the citizens considering years of government's poor track records of policy implementation and enforcement, and transparency in Nigeria. At the peak of 493 confirmed cases and 17 deaths of COVID-19 in Nigeria, the funeral ceremony of Mallam Abba Kyari, Chief of Staff to President Muhammadu Buhari, who died of COVID-19 disregarded the PMSRP policy. The second factor, the absence of trust, is an offshoot of the weakness of government policy measures over the years. For instance, the Nigerian government's failure to disclose critical details of the cash transfer programme cast doubt on how many Nigerians will benefit from the Social and Economic Rights Accountability Project (SERAP). Resnick (2020) argued that trust in political institutions refers to citizens' relative confidence that their governments are capable, reliable, impartial, and efficient. These trust variables are often shaped by partisanship, access to information and past interactions with government authorities.

Nevertheless, as the Nigeria examples indicate, the perceived weakness in national planning and executions and trust can be fragile. For instance, after the decision to ease the five-week lockdown on Monday, 4 May 2020, the government lamented the low level of citizens' compliance with the COVID-19 containment guidelines across Nigeria. As Adepoju (2020) asserted, the wide variations in the reliability of the success or failure of COVID-19 control measures in Nigeria hinged on the pandemic's politicisation and a lack of inter-institutional and public collaboration. According to Kelley (2020), the missing link in Sub-Saharan Africa in implementing COVID-19 guidelines by a public authority is the absence of accountability even in the face of strong government leadership and national policies. He argues that accountability implies openness about the pandemic, inclusiveness and partnership in the federal response, community engagement, and mobilisation to support the response.

Given the levels of support in Nigeria, the government’s fear and policy vision about the pandemic is different from the perspective of what the policy should be and the realities facing Nigerians. What this indicates is that the government has lost legitimacy, hence, legitimacy crises in Nigeria. Therefore, the foundation of the legitimacy crisis in Nigeria lies at the heart of policy disconnection. For Friedrichs (1980), the legitimacy crisis results from a perception dimension that takes both a behavioural and structural dimension considered primarily to be a fallout of source or perception, both of which may be traceable as partial symptoms indicators of such a crisis. In his study on *Why People Obey the Law*, psychologist Tom Tyler found that the value of legitimacy corresponds to securing social order and social action that enables the effective exercise of political authority, with a minimal threat or use of force (Greene, 2017).

In the report of the National Human Rights Commission in Nigeria, Adesope (2020) argued that two weeks into the lockdown, the security operative in ensuring compliance with the lockdown order in Nigeria killed 18 Nigerians while the Coronavirus had killed 12 people. However, the extent of some countries’ successes in obeying the lockdown measures and policies can also be an attribute of the political system’s nature. The nature of a political system, democratic or undemocratic, ensures a high degree of compliance. The compliance reflects the connection between the political system’s public authority units and the people to adequately protect human health and guarantee the maintenance of national units.

**The Nigeria Epidemiological Report Card and the Activities of NCDC**

To effectively achieve the mandate of the PTF, the National COVID-19 Pandemic Multi-Sectoral Response Plan developed a blueprint for a coordinated national strategy to respond to the pandemic. To achieve the task, the Federal Ministry of Health (FMOH) and its agency, the Nigeria Centre for Disease Control (NCDC), coordinate daily epidemiological summaries and review global epidemiological reports and other updates on the outbreak. At the multi-sectoral national Emergency Operation Centre (EOC), the NCDC, as of 17 February 2021, reported a total number of 149,369 cases confirmed; 21,860 active cases on admission; 125, 722 discharged and 1,787 deaths in 36 states and the Federal Capital Territory (FCT) (see table 1.) The daily update reveals Lagos state to have the highest reported cases of 53,725 followed by FCT 18,799, and Plateau 8,793.

*Table. 1: Geo-political representation of COVID-19 pandemic epidemiological report in Nigeria*

Geo-political zones in Naigeria	No. of Cases confirmed	No. Of Cases on admission	No. Discharged	No. Deaths
North Central	34519	10820	23406	293
North East	6011	969	4887	155
North West	15521	629(-4) From Zamfara state	14656	240
South East	8055	1202	6737	116
South-South	15325	2652	12329	344
South West	69938	5592	63707	639
Total	1493669	21860	125772	1787

*Source: NCDC (2021)*

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The National Emergency Operations Centre, led by the NCDC, deployed Rapid Response Teams to the affected states in Nigeria to support response activities. It has engaged media houses to update Nigerians on the intensive national risk communications campaign about the Coronavirus. This campaign ensures Nigerians observe social distancing thoroughly, washing hands with soap and water and alcohol-based sanitisers, report to NCDC on noticing COVID-19 symptoms through its website, WhatsApp, Twitter/Facebook, and avoid large gatherings. In addition, using face masks and observing basic hand and respiratory hygiene has been made mandatory. Through the Ministry of Health, the NCDC has continually engaged with health officials across the country. It has increased its resource mobilisation to support states affected through the deployment of Surveillance Outbreak Response Management and Analysis System (SORMAS) to states not using SORMAS but with coronavirus cases (NCDC, 2020).

Notwithstanding, these measures provided a national framework and leadership coordination of the various health and non-health functional areas at the federal, state, and local levels. However, rather than these measures serving as workable alternative solutions for contact tracing, testing, treating and vaccinating, they generated three contending narratives. The first narrative is health trajectories. Next is the political narrative that characterised the public authorities in Nigeria. The last is the economy spheres. Together, these narratives create a circle of legitimacy crisis that surrounds public authority governance in Nigeria.

## **Health Trajectories of COVID-19 Pandemic in Nigeria**

Historically, the medical research movement era started in the early 1900s with an aspiration from the scientific community to solve health and social problems. The reason for the movement is that sciences that contribute to the knowledge of the human body and its process are the technical resources of treatment and prevention. This means well-equipped laboratories with highly trained medical personnel and elaborately organised medical centres with teaching and research facilities under the auspices of medical practitioners who give all of their time to the patient and investigation care are vital for a modern medical school of a high standard (Rockefeller Foundation Annual Report [RFAR], 1920)

So, while the scientific community has set the agenda for reform, there has not yet been identified any large federal agency or international health body to assist in funding the public health agenda. Similarly, a general census that increases funding by public authorities for prevention and, at best, total or partial control of killer diseases is not in place. Nonetheless, Mr John D. Rockefeller Snr (senior) and his son John D. Rockefeller Jr. (Junior) were among the leading international community members to fund such projects. After establishing the Rockefeller Foundation in 1913 (RF), Mr Rockefeller Snr, in 1920, initiated health projects and medical schools in the United States, Canada, UK, Belgium, China, Brazil, and West Africa, as well as the Central America region. In these countries and regions, the foundation supported medical training centres and campaigns against hookworm, yellow fever, and malaria (RFAR, 1920).

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In Nigeria, the journey for medical research development started with the Yellow Fever Commission by the Rockefeller Foundation on the West Coast of Africa in 1925. In that year, the commission built a Research Unit in Yaba, Lagos State, Nigeria, and subsequently established the West African Council for Medical Research (WACMR) in 1954. In 1972, Decree No. 1 established the Medical Research Council of Nigeria (National Institute for Medical Research [NIMR], n.d). On 29 September 1977, in the exercise of the powers conferred on him by section 3 of the National Science and Technology Development Agency Decree 1977 No. 5, the Head of the Federal Military Government, General Olusegun Obasanjo, with the approval of the Federal Executive Council, established the Nigerian Institute of Medical Research (NIMR). The NIMR was responsible for researching health-related problems such as parasite and infective diseases and engaged in operation research to control diseases endemic, research, and training of scientists in medicine in Nigeria, among others (Nigeria Decree [ND No.5], 1977). Whereas the NIMR is concerned with human medicine and research development, it has no formal guideline for human subjects' research (Adebayo, 2020).

However, in 1987, an independent international commission on Health Research and Development was commissioned by the Council on Health Research for Development (COHRED) to improve people's health in developing countries. The release of the commission's report in 1990 led to the establishment in 1993 of the COHRED, with a priority on strengthening Essential National Health Research (ENHR). In line with COHRED and ENHR, the Nigerian government set up the National Health Research Advisory Committee (ENRAC) in March 2000 (Adebayo, 2020).

In 2004, the Nigerian government established the National Health Act, with the aim of defining the national health system and spelling out the health actions at the federal, state, and local levels in Nigeria. Under this scheme, Primary Health Care (PHC) became the engine of Nigeria's health system. To date, the PHC is the bedrock of the Nigerian health system and the first level of contact between Nigerians and their health system (Nigeria National Primary Health Care Development Agency [NPHCDA], 2019). In November 2018, the Bill for an Act to establish NCDC was signed into law by President Muhammed Buhari to protect the health of Nigerians through evidence-based prevention, integrated disease surveillance and response activities, using a One Health approach guided by research and led by a skilled workforce (NCDC, 2021).

Despite the historical development of medical research and the health sector in Nigeria by the public authorities, the health care sector has come under severe health emergency. Part of the health emergency has been orchestrated by the activity of public authorities and policymakers in Nigeria. The activity revolves around the error of omission through bureaucratic interference to underfund the health sector. Generally, the idea of prevention and protection of the community against contagious diseases requires the government to prioritise policy and increase funding for medical practitioners' research and training. However, in Nigeria, public authority holders are deprioritising the health sector with dwindling health budget allocation for years.

In that context, Ejide (2019) argues that no less than 3.9% to 5.8% of the entire national budget was allocated to Nigeria's health sector between the fiscal years of 2010 and 2019. This



goes contrary to the Abuja Declaration of April 2001 that mandated African governments to allocate a 15% national budget to health for the 19 years that followed. While countries such as Rwanda, Botswana, Niger, Zambia, Malawi, Togo and Burkina Faso have all implemented this percentage, Nigeria is yet to do so despite the deteriorating health care system. In 2020, the Nigerian government slashed the budget from 44,498,247,834 billion to 26,457,743,000 billion under the Basic Health Provision Fund (BHCPF). While the health budget stood at 5.9% against the 19% required by the Abuja Declaration, Onyeji (2019) insists that basic statistical calculation reveals that the revised budget is valued at approximately 133 per person in Nigeria for one year for a projected 200 million Nigerians. The neglect of the health sector by public authorities has given rise to three complex scenarios: an increased cost resulting from medical tourism outside Nigeria, mass exodus through medical emigration, and worsening public health disaster in Nigeria.

First, Akor (2018) states that medical tourism rose from N359.2 billion to more than 360.1 billion annually as of 2019 (Voice of America, 2019). Second, medical emigration has become the order of the day. Adegoke (2019) asserts that more than 5,000 Nigeria-trained doctors are registered medical practitioners in the United Kingdom, excluding other popular destinations such as Canada, the US, and Saudi Arabia. In the last 20 years, Momoh (2019) posits, 35,000 Nigerian medical personnel immigrated to Europe, the US, and Asia for medical practices. Ironically, Igoni (2020) argues that Nigeria needs roughly 300,000 medical professionals to actualise the WHO recommended doctor-patient ratio of 1:600 instead of the alarming under 40,000 doctors (1:3,500 ratio) currently practising in Nigeria. Due to poor incentive and the absence of modern facilities, the rise in brain drain and medical emigration in Nigeria is foreseeable in the present time, with an anticipated increase in the future. Third, health emergencies and disaster cases like the Lassa fever, cerebrospinal meningitis (CSM), yellow fever, lower respiratory infection (LRI), HIV/AIDS, cholera, measles, monkeypox, tuberculosis and acute flaccid paralysis (AFP) have claimed more lives than could have been prevented in Nigeria.

To be specific on public health disaster, Muhammad, Abbulkareem, & Chowdhury (2017, p. 8), contend that as far back as 2017, much of the top 10 causes of death in Nigeria were malaria (20%), LRI (19%), HIV/AIDS (9%), diarrheal diseases (5%), road injuries (5%), protein energy malnutrition (4%), cancer (3%), meningitis (3%), stroke (3%), and tuberculosis (2%). In a similar vein, the World Bank (2018, p. 7) states that malaria (30%), diarrhoea (26%), and pneumonia (18%) accounted for 74% of deaths in 2018 in Nigeria. In 2019, causes of death changed in sequence going in the order of lower respiratory infections; neonatal disorders, HIV/AIDS, malaria, diarrheal diseases, tuberculosis, meningitis, ischemic heart disease, stroke and cirrhosis (Centres for Diseases Control and Prevention [CDC], 2019). In 2020, between January and February, 26 of the 36 states in the country and the FCT have reported 472 confirmed cases of Lassa fever with 70 deaths making a case fatality ratio of 14.8%. (Aljazeera, 2020). NCDC also reported that between 2019 and 2020, the total cases suspected of Lassa fever stood at 6881. Of these, there were 1,541 confirmed cases and 311 deaths (NCDC, 2020).

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Amidst the rising cases of COVID-19, Saleh and Jimoh (2020) mention that between April and May 2020, mysterious deaths of 471 were reported in Yobe state, 100 in Jigawa, and over 150 in Bauchi. In relation to the mysterious deaths in Kano, Mohammed (2020) insisted that Kano city witnessed 150 deaths caused by complications from hypertension, diabetes, meningitis and acute malaria and not from the COVID-19 pandemic. Despite this number of deaths in northern Nigeria, it took days for a preliminary investigation to ascertain their causes. While the Kano state government downplayed the fear of death from Coronavirus, the public authorities' negligent character in Nigeria appears to affirm the omission and crisis in the country's primary healthcare system.

Even when the legislative arm attempted to work on health care in Nigeria, the issue generated controversy. In 2020, a proposed piece of legislation titled the Infectious Disease Act, which aimed to address the Federal Government of Nigeria's coordinated response to infectious diseases, was plagiarised from Singapore. Durojaiye (2020) contends that apart from the bill's title, Infectious Disease Act, 63 sections of Part One to Part Five of the Nigerian Act were plagiarised verbatim from the Singaporean Infectious Disease Act of 1977. The bill, which was supposed to create legal guidelines on how best the Nigerian government can manage outbreaks like the coronavirus pandemic to replace the National Quarantine Act of 2004, was a subject of controversies (Hundeyin, 2020). While the bill has been challenged in courts in Nigeria, the House of Representatives speaker, Honourable Femi Gbajabiamila, insisted on the bill's good intentions against worries by the public. Even with a good intention, the NCDC Director-General, Chikwe Ihekweazu, came out publicly to distance himself and the agency from the proposed bill on the ground that necessary stakeholders were not duly informed and considered the bill ill-timed.

## **Political Contending Narrative of COVID-19 pandemic in Nigeria**

The fight against COVID-19 in Nigeria and the activities of public authorities has generated a political contending narrative. As an entirely different narrative from the health-related trajectories, the political narrative has at least two strands of controversy. It is political because it has narratives that are directly related to the governance of public authority. As such, the public authority deliberately used propaganda to execute and manage the COVID-19 pandemic. The first strand of controversy in this relation offers an interpretation of the conspiracy between the business elite and Nigeria's government. The business community focused its attention on the government rather than on the people during the pandemic. The second strand discussed the Nigerian government's appetite to borrow money from the international financial institutions to fight COVID-19 and its corrupt tendency to mismanage the funds.

With regard to the first strand of controversy, there is obviously no crime for the private sectors to support the government in tackling the COVID-19 outbreak in Nigeria, but it becomes rational to ask why private donations should go to the government rather than to the people during the pandemic. The coalition of private donors to support the Nigerian government was led by Africa's richest businessman, Aliko Dangote, and other business fellows in the banking, telecommunication, oil, and food manufacturing sectors. Given the idea of corporate social responsibility (CSR),

any attempt to substitute their social responsibility with a donation to the government during the pandemic represents a calculated political gain. The business community's knowledge of the economic hardship that most Nigerians face before, during, and after the lockdown and their awareness of the Nigerian government's insensitivity towards Nigerians' plight render the justification for donations to the government worthless.

Fasan opines that while Coalition Against COVID-19 (CACOVID) in Nigeria has contributed ₦21.5 billion to the Nigerian government, corporate donors and philanthropists in the United States gave palliatives to the vulnerable and distressed people (Fasan, 2020b). In the United States, such gestures led by Jeff Bezos, founder of e-commerce giant, Amazon, donated \$100m to Feeding America. Jack Dorsey, the chief executive of Twitter, pledged \$1bn to a charity running a food programme for the poor. Reacting to the responsibility of establishing a food bank for the people during COVID-19 by private individuals, as part of their CSR, Morgan (2020, p.1) asserts:

Most people's lives have been completely upended by the Coronavirus sweeping the world. While the pressure is on, and governments are overloaded, it is up to business, large and small, to do things that will better their customers, employees and the community at large, until this difficult time passes.

In Nigeria, private individuals can 'fill the gap' as their CSR by finding ways through 774 local government and 119,973 polling Units in Nigeria to give back to their communities by providing hand sanitisers, financial support, food banks and beverages to vulnerable Nigerians during the unprecedented moment. However, while private individuals procured essential medical equipment and built isolation centres to support the government, the Nigerian government's transfer of food, cash and palliatives to assist COVID-19 victims was not devoid of controversy.

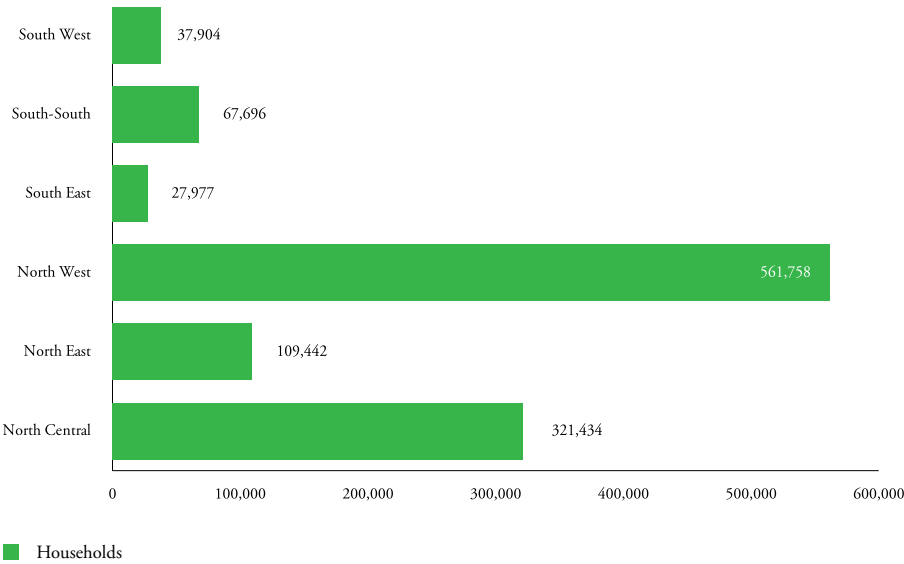
The palliative controversy in Nigeria redefines the failure of a political system, particularly the output property as government outputs to provide palliatives failed to commensurate with the demand and support from the inputs. As such, rather than positive feedback from the people, negative feedback was the order of the day. For instance, Nigerians' national embarrassment of scrambling for food like refugees on national television demonstrates a betrayal of the government's trust. Although most state governments and private individuals provided palliatives, however, the distributed food commodities were insignificant compared to undistributed stockpile of food items hoarded and later discovered in warehouses across nine states in Nigeria including Lagos state, Adamawa states, Taraba states, Ekiti state, Osun states, Kwara state, Plateau state, Kogi state, and Kaduna state. Public authorities denied the accusation of food hoarding while millions of Nigerians were starving. Dabang and Ukomadu (2020) assert that the bizarre scenes across Nigeria further eroded people's trust in government. In her view, the head of Social Action Nigeria, Vivian Bellonwu, maintains that the amount of food kept in storage is an indication of systematic failure (Obiezu, 2020).

During the government distribution exercises, gatekeepers and politicians hijacked the scheme to score cheap political points in the distribution affairs. Above all, it was sectional to meet only some zones and ethnic groups in Nigeria. In the end, it exposed the low level of transparency in

government as the determinant sharing formula for the beneficiaries in the palliative plan was not in the public domain. In the disbursement exercises across the six geo-political zones in Nigeria, the Northern regions were topped by household beneficiaries (see figure 2). In states ranking, some northern states received more than some zones in the distribution exercises.

Similarly, the top states in household beneficiaries were from the Northern states such as Katsina (133,227), Zamfara (130,760), Jigawa (99,044), Kano (84,148), and Plateau (78,430) (Okon, 2020). The comparison of the distribution with states from the South is striking. While the total household beneficiaries from the top five states in the North stood at 525 609, the total households' beneficiaries in 15 out of 17 states, excluding Lagos state and Ogun states, from South West, South East, and South-South zones stood at 133,577, slightly higher than that of one state in the North — Katsina state (see figure 2).

Figure. 2: Household palliative distribution by Geo-political zones in Nigeria



Source: Okon (2020)

In response to the imbalance in distribution, Obinna, Iniobong, Odog, & Kwen (2020) argued that the series of allegations such as discrimination and politicisation emanated from the distribution of palliative packages of N20,000 cash to help ease the lockdown. The issue of doubts in the distribution originated from the criteria employed to ascertain the poor of the poorest because some states and individuals benefited more than others did (Obinna *et al.*, 2020). The level of politics in the household beneficiaries and the sharing formula has further deepened Nigeria's ethnic animosities.

The second strand of the controversy focused on the status of funds borrowed by the Nigerian government to tackle COVID-19. In April 2020, through the United Nations, the European Union gave the Nigerian government the sum of £1.2 million to provide lifesaving preparedness and response activities to Coronavirus (UNICEF, 2020a). The government also received medical supplies of 10,000 test kits, 15 oxygen concentrators, PPE, emergency health kits and other vital supplies (UNICEF, 2020b). Apart from this, the Executive Board of the International Monetary Fund (IMF) approved Nigeria's request for an emergency loan of 3.4 billion US dollars to meet the urgent balance of payment needs arising from the COVID-19 pandemic (IMF, 2020). This loan is outside the request made by the Nigerian government to the World Bank for an additional \$2.5 billion and African Development Bank (AFDB) for \$1 billion to fund the coronavirus fight (Carsten, 2020).

The borrowing plan supported by the multilateral lenders such as IMF, World Bank, China Eximbank and German Development Bank in the guise of fighting COVID-19 and a "quest to sustain the economy" amounts to the continuing act of mortgaging the entire country in the long run. Given this, Chiejina (2020) stipulates that Nigeria's total debt stock stood at 16.88% when it rose from N25.701 trillion in September 2018 to N26.215 trillion in September 2019. However, with the recent approval of \$22.7 billion foreign loans for the federal government in the 2016-2018 External Borrowing Plan, the total debt stock would be about N33 trillion and 21 Debt/GDP ratio (Elumoye, 2020). It is not debatable that the reality of Nigeria's borrowing plan has shown that over the decades, public authority holders stash the monies borrowed in foreign accounts.

Considering the Former Nigeria Military Head of State, Late Sani Abacha's loot of \$321 million recovered and the loans from the multilateral lenders, it appears that the measures and actions adopted to utilise these funds have not been matched so far with available results. In other words, the funds have not been commensurate with the objectives for borrowing, recovered loots and donations. Even where the government took measures to address Nigerians' economic predicaments, both in the formal and informal sectors, they seem to be deliberately slow, inconsistent, and selective in measures and approach.

## **The Economic Spheres of COVID-19 Pandemic in Nigeria**

As COVID-19 ravages continents and countries around the world, the economic shock would be devastating. According to this study, the prevalent crises across the world vary depending on how strong and weak each nation's economy was before the outbreak. The point here is that countries with economic strength may be able to minimise the anticipated economic shock. In contrast, weak economies, mostly in the developing countries, are more likely to go into economic recession. As business collapsed, the economy and investment crumbled, and unemployment rose. The 'desperation' by world leaders to get back the economy appears to have created debate and division among policymakers, medical practitioners, leaders and citizens.

The debate has been between the proponents of saving humanity before the economy, on the

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one hand, and the supporters of salvaging the economy and saving a life, on the other hand. The reality is that the epidemiological update of the coronavirus pandemic has created a global economic shock. Even without the debate, public authorities' support packages worldwide and the multilateral lenders' economic roadmaps will inevitably avert economic shock in countries and continents. However, the UN report estimates that 3.3 billion workforces are out of work (BBC, 2020) and that the economic shocks are more severe than the 2008 financial crisis. Given the extraordinary nature of the outbreak-induced economic woes, potential economic global bailouts will be needed (Masters, 2020). The warning signals and indicators of COVID-19 would spotlight the mono-cultural economy of Nigeria, dependent on oil, as the economic recession looms.

Are-Adib (2020) opines that the economic and social impacts of COVID-19 will have multiple adverse effects across the continent. For Nigeria, revenues declined due to dependency on oil prices fluctuations. Despite public authority's years of preaching of diversification in Nigeria, it appears that the oil price collapse has not decimated the Nigerian economy to force the government to implement diversification and stop reliance on oil exports as the primary source of revenue. Ozili opines that Nigeria is not new to economic recessions such as the global financial meltdown in 2009 and the oil price collapse in 2016. However, he asserted that the impending 2020 economic crisis would be difficult to revive because economic agents who are supposed to lend a helping hand are experiencing the economic shock (Ozili, 2020, p. 2). For that, national governments' economic stabilisation to ensure quick stability while achieving maximum results must include oil-dependent and non-oil dependent economic strategies and people-centred decision-making initiatives.

Okunade (2020) insists that the economic woes caused by COVID-19 in Nigeria have cut the oil revenue target from \$57 to \$30 per barrel and affected the planned sale of public assets to finance the 2020 appropriation bill. The drop in oil price is also affected by recurring instability between OPEC members' states and Russia. Nwagbara (2020) argues that Nigeria's reduction of N1.5 trillion in capital expenditure by 20%, recurrent expenditure by 25%, and the idea to use 50% of privatisation proceeded to finance the budget evidenced in the Nigerian economic situation. Our historical economic shock shows that Nigeria's real GDP dropped by 1.58% in 2016, 0.82% in 2017, 1.93% in 2018, 2.27% in 2019, and from 5%-10% in 2020. On the contrary, unemployment rose from 14.23% in 2016 to 20.24% in 2017, and then to 23.13% in the third quarter of 2018. From there, it went up to 28.65% in 2019 and surged to above 35% in 2020. Nevin (2020, 18) predicted that Nigeria should expect fiscal crises at both federal and state levels and depleted external reserves. This symptom of Nigeria's economic downturn will further generate other symptoms such as crisis in the production of goods and services, non-payment and reduction of salaries by the state government, food shortage, and collapse in the informal sectors.

Some of the economic symptoms in Nigeria, according to Velde (2020), include a fall in government revenues, pressure on the Naira, drop in stock markets, and income drop of the majority of the population. Globally, the International Labour Organisation (ILO 2020) estimated that apart from the expected 1.6 billion informal economy impact of the COVID-19 in April 2020, 2 billion

people, roughly 6 of 10 workers in Sub-Saharan Africa and Southern Asia, are likely to be affected by the economic shock. The estimation stipulates that 94% of lower-middle-income countries with the largest informal employment such as India, Bangladesh, Pakistan, and Nigeria would be worst affected. Accordingly, Obiakor (2020) asserts that the International Labour Organisation maintained that 80% of Nigeria's workforce is in the informal sector making daily wages and, as such, most vulnerable to the negative economic shocks of COVID-19 pandemic.

Given the ILO report, Onyekwena and Ekeruche (2020) assert that the effects of COVID-19 will lead to a fall in household consumption and uncertainties that come with the pandemic, which will make it extremely difficult for the Nigerian government to weather the crisis. In that case, the warning was the approval given by Nigeria's President Buhari for \$150 million deductions from the Stabilisation Fund managed by the Nigeria Sovereign Investment Authority (NSIA). Udo (2020) argues that the deduction aimed to support the June 2020 Federal Account Allocation Committee (FAAC).

Notwithstanding the anticipated crises, Adeyeye argues that Nigeria has the potential to diversify given its abundant reserves of natural resources such as iron ore, gold, limestone, lead, zinc, coal, tin, bentonite and barite. However, he lamented that as of 2019, these potential natural resources contributed only 0.3% to the national GDP and oil contributed 65% despite its limited potential employment opportunities and revenue generation which is respectively estimated at just over 5 million jobs and 8 trillion naira by 2025 (Adeyeye, 2020).

## **Government Fiscal Measures against COVID-19 Pandemic**

To facilitate the effect of COVID-19 and other diseases in Nigeria, the federal government proposed two critical fiscal policies and vaccine budgets. The first fiscal arrangement is through the apex bank, the Central Bank of Nigeria. The fiscal stimulus includes a 50billionnaira credit facility for household and small-scale enterprises besides the 100billionnaira loan to the health sector and 1 trillion naira to the manufacturing industry. In addition to this, the apex bank revised the interest rate downward from 9% to 5% starting from 1 March 2020 and adjusted the exchange rate from 306 to 360 and devaluation of the naira (Onyekwena & Ekeruche, 2020).

The government also introduced regulatory forbearance grants towards all Deposit Money Banks. By doing so, CBN considers temporary and time-limited restructuring of the tenor and loan terms for businesses and households most affected by the coronavirus pandemic, mostly from the oil and gas, agriculture, and manufacturing sectors. It also granted a further one-year suspension on all principal repayments in all the intervention facilities from the apex bank in Nigeria (Odotola 2020). Secondly, the government earmarked a sum of N22.73 billion for GAVI/Immunization, N4.8 billion for Polio Eradication Initiative, N815 million for Non-Polio SIA Vaccine, and an additional N4 billion for Procurement of RI Vaccines and devices. The government set aside N1.41 billion for its expanded midwives service scheme, N5.5 billion for counterpart funding on the global fund for health, and plans to spend N554.92 million on Kits' Procurement Commodities for Community Health Influencers (Adepoju, 2020).

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On the other hand, the federal government's legislative backing of the efforts became evident on 24 March when the House of Representatives introduced and passed the "Emergency Economic Stimulus Bill 2020" to cushion *COVID-19* effects on the country. Despite all these tax measures to monetary and fiscal policy, the exclusion of most Nigerians, particularly in the informal sectors whose businesses are not registered, calls for greater concerns. Similarly, the monopoly given to the newly established Private Limited Company, microfinance bank, to manage a huge amount of 50 billion naira is questionable. The newly incorporated microfinance bank came into existence in 2019, and giving it such a monopoly without considering the bank's national coverage is also suspicious. With over 900-microfinance banks in Nigeria and stringent collaterals such as "moveable assets and deed of debenture", the need for an urgent review is vital to avoid defeating the fund's aims. Most of these households in Small and Medium Enterprises (SMEs) cannot meet the requirements to qualify for loans.

Also, the public sentiments in Nigeria share that any fund budget for the procurement of medicines and supplies in health-related areas offers public authority holders another opportunity to engage in corrupt practises. As Fasan (2020a) echoes, one thing is certain amid the Nigeria Central Bank N1 trillion stimulus package and N500 intervention funds on COVID-19 — no credible evidence of where a fraction of the money is going to— hence; misappropriation such as corruption will raise the risks of COVID-19.

## Conclusion and Recommendations

The coronavirus pandemic that initially started in China, Asia, is now a global health catastrophe. In all continents, the gradual rise in coronavirus cases has put pressure on public authorities. Despite nationwide vaccination in some developed and developing countries, public authorities have still faced multiple challenges such as health and economic challenges. In Africa, Coronavirus has pierced the continent's health, economic, and political space as many countries, including Nigeria, have adopted a different approach to curtail the spread of COVID-19. Therefore, as the number of deaths rose globally, governments worldwide urged citizens to observe social distancing and maintain personal environmental hygiene.

The government's National COVID-19 Pandemic Multi-Sectoral Response Plan has come under severe scrutiny and suspicion in Nigeria. Despite the national plan to mitigate the health and economic impacts of COVID-19, citizens' responses to the national plans appear to be indifferent, particularly to the government's multi-sectoral response plan. The general understanding of Nigerians' lack of interest in the national plan lies at the heart of systematic political failure. The failure is the inability of outputs and decisions from the political system to be derived from the inputs (demands and supports) in the environment in a never-ending chain, hence, a wider gap between the government and the citizens in policy responses. The implication is the recurring decimal over the years of the circle of legitimacy crisis in Nigeria.

A legitimacy crisis is a product of a decrease in trust and transparency in governance. In that



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situation, the support of the citizens towards the government's ability and its institutions to address the society's challenges is doubtful. The absence of transparency and trust in the fight against the COVID-19 pandemic has neutralised Nigeria's public authority efforts. In such an environment of mistrust, there is a deficiency of governance that flows from the federal government to the local government and to all citizens. The degree of mistrust in all spheres determines the degree of legitimacy and response from the people. The circle of mistrust, while blurring government strategies, has also created controversies.

The article identified three possible accelerated strands of controversies that have contributed to the circle of legitimacy crisis and mistrust during Nigeria's COVID-19 governance. The first is the deplorable health emergencies. Decades of Nigeria's public authority neglect of the health care system has undermined Nigerians' demand for concrete steps to address the country's healthcare system. The second controversy is the political dimension, a narrative of concern towards the borrowing agenda from international financial institutions to finance the cost of COVID-19-related measures. Historically, Nigeria's authority has a borrowing appetite; however, to meet up with the demand for borrowing has not been sufficiently utilised over the years. While COVID-19 offers an excuse to borrow, government officials have track records of corrupt practices in Nigeria. The scepticism, therefore, of Nigerians toward government borrowing has further created mistrust in governance in Nigeria.

The last controversy is the economic spheres and anticipated economic shock of COVID-19 to the Nigerian economy. Previous governments have discussed diversification; however, the economic shock impact would have been lesser if Nigeria had a diversified economy. While economies worldwide are fighting the effect of Coronavirus, the degree of fiscal challenges for Africa's most populous nation is still dependent on oil prices and focuses on stimulating microeconomic indicators. Considering the impact of COVID-19 on Nigerians' socio-economic well-being, the North's insecurity will further hamper local production of agricultural products with anticipated food insecurity.

Thus, this article recommends that the Nigerian government adopt open and transparent governance to regain legitimacy from citizens and to address the fallout with the public. It should work on increased healthcare budgeting to fix the health sector, strong legislation against government officials' medical tourism, and avoidance of undue political interference in health policy. Besides, adequate funding should be earmarked from the annual budget to research existing health emergencies in Nigeria. Fiscal, monetary and other measures must be objective enough and realistic to support the informal sectors and identify the relevant households and individuals. The government should suspend the regular state government tax on the informal sectors to demonstrate the government's sincerity and genuineness.

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# Conceptions of the COVID-19 Pandemic among Religious Leaders in Nigeria: Implications for Responses and Coping Mechanisms

Anene Chidi Pensive

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## Abstract

This qualitative study examines the concomitant relationship between the different conceptions of the COVID-19 pandemic among religious leaders in Nigeria and its implications for their various response and coping mechanisms. The study used secondary sources such as newspapers and magazines, scholarly texts, journal articles, and the internet for content analysis and conclusion. It argues that responses to COVID-19 safety rules, lockdowns and coping measures among the religious organisations, denominations and sects in Nigeria were outcomes of their conceptions or misconceptions about the disease. It was observed that while some religious leaders and followers alike dismissed COVID-19 as a farce resulting from conspiracy theories of diseases, others accepted the existence of the pandemic. The study contends that while denial of the disease led to resistance and opposition to the directives issued by the Nigerian Centre for Disease Control (NCDC) to curb the spread of the disease in the country, belief in the reality of the disease and its manifestation as an act of God resulted in a positive response to the directives passed to mitigate the pandemic. The study concludes that several religious leaders would not have devised credible coping mechanisms in the church services without the government's enforcement of the lockdown.

## Keywords

COVID-19, implications, lockdown, Nigeria, religious leaders

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## Introduction

In Nigeria, widespread conventional religious practices range from regular attendance of churches and mosques to personal devotions of reading the Bible and the Koran. Additionally, there are traditional religious worshippers. In Nigeria, the two major religious groups—Christians and Muslims—usually observe their holy week of Easter and Ramadan in a large gathering of processions by worshippers in churches and mosques, respectively.

However, for the first time in the country's history, a total lockdown occurred due to the COVID-19 pandemic, which also affected places of worship. The federal government issued a sit-at-home order from March 30, 2020, in some states of the nation, such as Lagos, Ogun State and Abuja, to contain the spread of the disease to the states and other parts of the country. Some state governors followed suit in imposing the same restrictions in their states. The restriction order of two weeks was further extended by another two weeks and furthered into months where all social gatherings and parades in churches, mosques, weddings and funerals were banned (Campbell, 2020).

However, while the Muslim and Christian authorities, as represented by the Nigerian Supreme Council for Islamic Affairs (NSCIA), the Christian Association of Nigeria (CAN) and Pentecostal Fellowship of Nigeria (PFN), supported the lockdown and social restriction measures as ordered by the government, some minor groups and religious adherents who conceived the COVID-19 pandemic as a farce showed initial rejection and disdain toward the order given by the government. The government, which did not find such disobedience funny, ordered such leaders' immediate arrest and prosecution. (Campbell, 2020). In some extreme cases, the government ordered the closure of such churches and mosques, which served as a lesson for others.

However, as the number of Coronavirus cases started rising and the government bent on enforcing its restriction orders, even those who initially did not believe in the existence and severity of the pandemic were compelled to observe the safety measures. There have been hardships across all sections of the country, and the government could not cushion the effects of such difficulties. So, citizens devised coping mechanisms of survival despite their long-held conspiracy theories. To this end, this study examined the conspiracy theories of the coronavirus pandemic, the conceptions of Nigerian religious leaders about the COVID-19 and the various responses and coping mechanisms developed by both religious leaders and their followers.

## Conspiracy theories on the Coronavirus pandemic

A conspiracy theory is couched on the belief that powerful forces secretly manipulate certain events or situations with harmful intents. Conspiracy theories on the Coronavirus ignore scientific evidence and falsely blames individuals and groups. According to the European Commission (2020), conspiracy theories have six features, which include an alleged secret plot; a group of conspirators; a false suggestion that nothing happens by accident and that there are no coincidences; claiming that nothing is as it appears and that everything is connected; dividing the world into good or bad; and scapegoating people and groups. According to Ellis (2020),



Conspiracy theories have dogged disasters and outbreaks of illness probably forever. While the Black Plague ravaged Europe in the 1300s, people became convinced that their Jewish neighbours were furtively poisoning good Christian wells for reasons. Conspiracy theories about the Wuhan coronavirus, which range from believing the disease is a bio-weapon to the result of eating bat soup, are playing an ancient chord. As always, it sounds anxious, racist, and distinctly out of tune with reality.

Though conspiracy theories have a long history of emergence, the actual term “conspiracy theory” emerged much more recently. It was only a few decades ago that the term took on derogatory connotations. A version of its origin claims that the CIA invented the term in 1967 to disqualify those who questioned the official version of John F. Kennedy’s assassination and doubted that his killer, Lee Harvey Oswald, had acted alone (**theconversation.com, 2020**).

The more extreme version claims that the CIA invented the term because “conspiracy” and “theory” had never been combined before. A more moderate version acknowledges that the term existed previously but claims that the CIA intentionally created its negative connotations and turned the label into a tool of political propaganda (**theconversation.com, 2020**). The more moderate version has been popular in recent years for two reasons. Firstly, it is easy to disprove the more extreme claim that the CIA invented the term. As the contention on the origin of conspiracy theory rages on, there is a generally held belief that “conspiracy theory” emerged around 1870 and became more frequently used during the 1950s. Even die-hard conspiracy theorists have a hard time trying to ignore this. Secondly, the more moderate version received a significant boost in popularity a few years ago when the American political scientist, Lance DeHaven-Smith, propagated it in a book published by a renowned university press. However, despite the differing claims by the two versions about the origin and development of the term, the proponents of both versions invariably point to an official CIA document called “Concerning Criticism of the Warren Report” (<http://www.jklancen.com/CIA.html>, 2020) as their smoking gun. It was released in 1976 after The New York Times requested it under the Freedom of Information Act.

**Theconversation.com (2020) reported that** the document named above expresses concern about the considerable number of people who doubted the official investigation into Kennedy’s assassination by the Warren Commission, which found that Lee Harvey Oswald acted alone. It also aims to equip CIA contacts with arguments against those who challenge the findings and the official version of the event. For example, it emphasises that nobody in their right mind would have chosen someone as unstable as Oswald as a pawn in a larger plot. And it further points out the “logical fallacies of these alternative accounts” ([warp.povusers.org](http://warp.povusers.org), 2020).

**Conspiracy theories flourish because** they often appear as a logical explanation of events or situations which are difficult to understand. Such views usually start by raising a suspicion and a puzzle that require an answer to such questions as *who is benefiting from the event or situation, or more so, who is behind the making of such claims*. Any ‘evidence’ is then forced to fit into the theory (European Commission, 2020).

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People spread conspiracy theories to achieve a particular motive. They move most people to believe they are authentic, while others deliberately want to provoke, manipulate or target people for political or financial reasons through such mechanisms and sources. Thus, they may explore social and mass media as veritable instruments to manipulate the psychology of their followers. Conspiracy theories often target or discriminate against an entire group perceived as the enemy behind a real or imagined threat. They polarise society and fuel violent extremism. While most people who spread conspiracy theories genuinely believe in them, others deploy them cynically to achieve these effects.

Perceived “out-groups” of society are especially prone to be targets of conspiracy theories, hate speech and disinformation campaigns. These include people of different origin, religions or sexual orientations. In the context of COVID-19, specific groups were frequently falsely blamed for spreading the virus in Europe. These include people of assumed Asian origin, Jews, Muslims, etc. Once they have taken root, conspiracy theories can proliferate. They are hard to refute because anyone who tries doing that is part of the conspiracy (European commission, 2020).

**Conspiracy theories could have damaging effects in the following ways:**

- **They identify an enemy and a secret plot that threatens peoples’ lives or beliefs and spark a defence mechanism** that can fuel discrimination, justify hate crimes, and exploit violent extremist groups.
- **They spread mistrust in public institutions**, which can lead to political apathy or radicalisation.
- **They spread mistrust in scientific and medical information**, which can have serious consequences.

## **Conspiracy theories and the COVID-19 pandemic**

COVID-19 is a new disease caused by the most recently discovered Coronavirus. Uncertainty, fear and complexity of the COVID-19 pandemic have fuelled related conspiracy theories. They attempt to ‘explain’ why the pandemic happened and who is benefiting from it. A global study of 28 countries revealed that more than 3 in 10 people surveyed believe that a foreign power or another force is deliberately causing the spread of the COVID-19 virus (Gallup International, 2020).

**Misconceptions spread by proponents of conspiracy theories about the coronavirus pandemic include claims that:**

- The virus was artificially created (e.g. in a laboratory) by people with a specific interest (e.g. reducing world population).
- The virus was spread intentionally through 5G signals.
- Vaccines and cures are intentionally withheld to cause further spread and harm to people.
- Specific sanitary measures to counter the spread of the virus are used to intentionally harm or control society (e.g. vaccines, masks).

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Misinformation about a new, deadly [coronavirus](#) has gone viral. Conspiracy theories and wild claims have been spreading across the global internet since Chinese officials first announced, on December 31 2019, that [mysterious pneumonia](#) was sweeping through the city of Wuhan. Ellis (2020), corroborating the views of the European Commission, stated that falsehoods about Coronavirus fall into two major categories - conspiracy theories about the origins of the illness and misinformation about miracle cures. Some scientists believe the animal vector may have been [bats](#). One theory claims it came from bat soup, thus sparking racially tinged online outrage about supposed Chinese eating habits causing the pandemic. One of the most prominent pieces of [video](#) evidence was a segment from a travel show shot in 2016 in Palau. It is important to note that bat soup is not typical food in Palau, yet it was presented as such. Ellis further informed that another theory about the virus was people's expressed view that it was a bio-weapon that somehow escaped its secure place in the lab at Wuhan Institute of Virology. Contrarily, however, Ellis cited a former Israeli intelligence officer who himself [admits](#) that there is no evidence to back such a theory. Then again, another theory has it that a scientist husband and wife "spy team" stole the Coronavirus from Canada's National Microbiology Laboratory. A virologist was suspended following a "policy breach," but the [report](#) theorists reference makes no mention of her being a Chinese spy or ever illicitly sending a virus to China. Many felt that the virus was somehow a cover-up or a plot. Such persons claim that the disease was not new on the planet based on various alleged proofs. Despite a vaccine patent for a coronavirus, labels on cleaning products like Clorox and Lysol claiming to be able to kill it are still disbelieved. The one spreading across the globe now is called 2019-nCoV, and unfortunately, it cannot be treated with any known vaccine or Lysol.

The conspiracy theory did not escape Nigeria and its citizens. Driving the conspiracy theory home to our topic of discussion, some notable Nigerian religious leaders imbibed and propagated conspiracy theories on their pulpit, religious gatherings and through the internet. Nigeria is a highly religious country, and it is widely reported that many citizens trust Muslim and Christian clerics or other religious leaders more than they do the government (Adepoju, 2020). Adepoju (2020), using the public pronouncement made by Pastor Chris Oyakhilome of Christ Embassy, for example, informed that:

There was a huge social media buzz when Pastor Chris Oyakhilome, the charismatic leader of Nigeria's major Pentecostal churches, endorsed a theory connecting COVID-19 to 5G. It was evident in the aftermath that the local truth ecosystem was caught off guard and fumbled its way to respond. It emphasised the importance of spiritual leaders influence when it comes to public health information.

Thus, considering the large segment of the population that some of these religious leaders attract and the level of attachment and reverence their followers have for them, most of these adherents

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believed the conspiracy theories and disseminated them to their trusted friends and relatives. Such unsuspecting friends and relatives, in turn, spread the same to others, thereby worsening the spread. This led to some of the misconceptions, scepticisms and superstitions created around the coronavirus disease in Nigeria. Besides the above, some of the COVID-19 protocol breaches and non-adherence to the safety measures proffered against the disease during the lockdown arose from these conspiracy theories. For instance, Sheikh Sani Yahaya, through several sermons and press conferences, dismissed Coronavirus as a “farce - a ghost of the West maliciously created by some secret Western agents to prevent Muslims from performing their religious obligations such as pilgrimage, congregational prayers, preaching and handshakes” (Yahaya, cited in Ibrahim, 2020). Yahaya’s positing found positive punctuation in the religious undertone advanced by Pastor Chris Oyakhilome in theorising that COVID-19 and the 5G technology are products of a satanic secret agent, the Illuminati, to transform humankind into a hybrid of mechanical devices and pawns in the willing hands of Satan. This misconception of the realities of COVID-19 warranted Pastor Chris to vehemently kick against the lockdown directives by the federal government of Nigeria, whom he alleged were exploring the period to install the 5G antennas and their accessories secretly. The effect of such a stance by these religious leaders was a de-marketing of the health and safety tips for preventing the spread of the virus in Nigeria. Thus, it was difficult for many citizens to accept the virus’ existence or the government’s genuine intention regarding the lockdown. Worst still was, and still is, the acceptance of the authenticity of the figures of infected persons as are reeled out from Disease Control Centres and their claim of those who died from it. That Nigerians have long learnt to distrust their leaders, undoubtedly contributing to their resolve to anchor their trust in their religious leaders. This has not helped in any way in curbing the spread of the disease.

## **Conceptions of the COVID-19 pandemic among religious leaders in Nigeria**

While most religious leaders and organisations did not downplay the reality of the COVID-19 pandemic, a handful of them promoted the conspiracy theories. Below are some of the negative conceptions of the pessimists and positivists on the existence of the COVID-19 pandemic and its attendant lockdowns:

### **Conspiracy conception**

Notable among the pessimists who share the conspiracy theories of the COVID-19 pandemic were Sheikh Sani Yahaya (leader of the Islamic Reform Movement, Izala, and Pastor Chris Oyakhilome (founder and leader of Christ Embassy. Interestingly, both Izala and Christ Embassy have millions of followers across Nigeria and Africa.

In several sermons and press conferences, Sheikh Sani Yahaya dismissed Coronavirus as a “farce, maliciously created by some secret Western agents to prevent Muslims from performing their religious obligations such as pilgrimage, congregational prayers preaching and handshakes” (Yahaya cited in Ibrahim, 2020). Yahaya was quoted to have described COVID-19 as “a ghost of the West” - an illusion of Western origin. He stated that the virus was foretold in a 1981 novel titled

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“The Eyes of Darkness” written by Dean R. Koontz. Yahaya and some of his followers further pointed to several dystopian movies featuring global pandemics, such as “Outbreaks” (1995), “I am Legend” (2007), and “Contagion” (2011), to corroborate their claim that COVID-19 was a premeditated conspiracy (Ibrahim, 2020).

That Pastor Chris Oyakhilome linked COVID-19 emergence to the 5G technology is legendary. He fed his congregation with the idea that the disease was a mastermind of mainstream media corporations and some devilish scientists who were, and still are, bent on instigating a new world order” through the 5G technology. In fact, he pointed at Bill Gates and the Asian Tiger for being behind that “devilish” resolve. Amidst this growing attempt associating the 5G technology with the world government, Pastor Chris added religious colouration to this theory. Thus, in one of his online sermons on April 8, 2020, Pastor Chris made reference to Bible prophecies to psychologise his followers into believing that both Coronavirus and 5G technologies were consciously devised anti-Christ mechanisms employed by satanic secret agents to lure men into hell and deny them the hope of everlasting life. According to him, these satanic agents will soon introduce a COVID-19 vaccine, a serum filled with nano-microchips introduced into the human body. These microchips, controlled via 5G technology, are mere designs to read and influence human thought while undermining human free will. He thus alleged that it was primarily intended to coerce people to worship Satan instead of God. For him, therefore, the lockdown of cities across the nation by the Federal Government of Nigeria was a secret plot to facilitate the installation of a 5G technology that would ensure that motive. He contended that the microchips meant to be injected into the human bodies are the much prophesied “mark of the beast” as foretold in the Bible Book of Revelation. To drive home his point, Pastor Oyakhilome corroborated the earlier view of Yahaya, which subscribed to drawing inference from the dystopian Hollywood film “Divergent” (2014) that deals with the theme of mind control through a serum infused into the human body (Oyakhilome, cited in Ibrahim, 2020).

Nigerians are very religious and superstitious people. The conspiracy theories arising from the COVID-19 pandemic, no doubt, further entrenched their religiosity and superstitiousness. Thus, even those who seem to believe a little of the reality of COVID-19 anchor their belief of solution to the disease on divine interventions. That Nigerians violated the lockdown and restriction orders by attending churches and mosques and other social gatherings resulted from the above. Thus, rather than adopt the scientific and social measures proffered by the government for the prevention and control of the disease, Nigerians prefer the use of religious “armours” such as anointing oils, holy waters, chaplets, talismans, herbs or rituals (Abati, 2020) as preventive measures. Beyond face to face conviction, some grossly resorted to using social media platforms (e.g. WhatsApp, Twitter, Facebook and Instagram) to entrench their gospel, thus spreading among the people.

The economic effect of the pandemic was indeed colossal. Most religious leaders cashed in on the cold war between China and America to project fake news concerning the source of the virus. Such leaders promoted prejudice against China by inciting panic-buying, accusing China of proffering fake vaccines, and they, therefore, encouraged their followers to deliberately or ignorantly undermine medical advice (Hassan, 2020). They, thus, opined that lockdown, self-isolation and

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social distancing were un-African solutions to the pandemic (Abati, 2020).

### **The “Act of God” theory**

This conception arose in a swift criticism of the conspiracy theories. Pastor Mathew Ashimolowo and Dr Mansur Sokoto represented the theorists in this regard. Debunking the views of Oyakhilome and Yahaya, they attributed the origin of the COVID-19 pandemic to divine act. For Pastors Mathew and Mansur, COVID-19 emerged as a result of God’s anger against humankind. Though the duo did not reject modern biomedicine as a remedy in tackling the virus, they ultimately proffer prayers as the primary panacea for its eradication (Ibrahim, 2020).

The result of acceptance of the realities of the COVID-19 pandemic as a disease that requires safety measures has so far made Nigerians exhibit a high degree of compliance with the government directives, engaging in vigilant hand washing, practising social distancing and self-isolation, and avoiding going to work, school or crowded areas. Even most religious leaders agreed to stop large gatherings, forbade the shaking of hands and directed church members to pray at home and use hand sanitisers (Makinde, Nwogu, Ajaja & Alagbe, 2020; Olatunji, 2020).

### **Response from religious leaders**

No doubt, as the adverse effects of COVID-19 in Europe, America and Asia continue to filter the country, it dawned on religious leaders the need to have their followers come to the realities of the facts of the disease. As soon as the Federal Government, via the Presidential Task Force (PTF) on COVID-19 and the National Centre for Disease Control (NCDC), issued guidelines for safety and prevention of the spread of the disease, the umbrella body of Christians in Nigeria, Christian Association of Nigeria (CAN), responded positively by directing churches in the country to conduct services online or use house cell-based service. The CAN President pointed out to members of the body the imperative of adhering to the guideline by the government of not more than 50 congregants in a single service. He equally admonished member churches to start conducting online services to help curtail gatherings and keep them abreast of their spirituality. Again, the CAN President criticised affiliating church leaders who did not have online facilities to split their services into shifts to accommodate the spiritual wellness of members. Secondly, CAN called on all churches in the country to pray on the 22<sup>nd</sup> and 29<sup>th</sup> of March for an end to the pandemic in Nigeria and all over the world; for the protection of Nigerians from the disease, and for healing of those already infected by the disease (Premium Times, 2020).

Subsequently, the Catholic Bishops Conference volunteered all 425 hospitals and clinics nationwide for conversion and use as isolation centres. Hence state governors were encouraged to approach Catholic Bishops in their states to access these facilities (La Croix International, 2020).

Further directives included each branch or church providing alcohol-based hand sanitisers, regular handwashing with soap and water; maintaining at least one-metre distance from each other and anyone coughing or sneezing; avoiding the touching of eyes, nose and mouth; drinking of

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hot water regularly; practicing respiratory hygiene such as covering mouth and nose with elbows or tissues when coughing or sneezing; disposing of tissues immediately after use; and seeking early medical care if one had a fever, cough and difficulty in breathing (Premium Times, 2020).

As posited earlier in this work, apart from some recalcitrant religious leaders who saw the COVID-19 pandemic as a farce, most churches and mosques believed in the reality of the COVID-19 pandemic. It could thus be opined that religious leaders' negative attitude to the facts of the pandemic is a result of the distrust citizens have for the government and an ingrained psychological make-up of the Nigerian citizenry who see religious bodies as their last hope for both physical and metaphysical restorations. The churches responded by first subscribing to the fact that the COVID-19 pandemic is an act of God aimed at chastising a sinful man to bring him back to his creator and hinge on these long-ingrained psychotics.

But again, change of attitude by citizens could be seen when the churches and mosques and their leaders began to tow the line of government. The turn of event was that the shift in mindset by religious leaders to observing government directives resulted in the majority of citizens not only adhering to and supporting the government's directives for closure of churches and mosques but going further to use these churches and mosques as veritable avenues to engage in mass awareness campaigns for information dissemination on measures, guidelines and protocols for prevention of the spread of the disease. No doubt, the lockdown imposed hardship on the citizens. But again, government and donor agencies used the churches and religious bodies as distribution centres for palliatives. Besides, some of these religious bodies, like the Deeper Life Church, the Redeemed Christian Church of God, and the Catholic Church, assisted the government by donating palliatives in kind and cash (Wadibia, 2020).

Wadibia (2020), in his analysis of the response of the church to COVID-19, showed how Nigeria's Pentecostal pastors leveraged the pulpit to voice concerns relating to the COVID-19 pandemic.

According to him,

Nigeria's Pentecostal leadership responses range from archconservative strands of socio-theological thought that highlight the perceived decay of global human ethics as the chief trigger underpinning the spread of COVID-19 to politico-theological arguments that posit that the best way to overcome the COVID-19 crisis involves adhering to the recently imposed social and public health policies of the Nigerian federal government. These arguments call for social distancing, a ban on crowds of more than fifty people, a cessation of movement in some of Nigeria's major urban centres (i.e. Lagos, Abuja, and Ogun State) and an emphasis on personal agency through renewed individual commitments to high personal hygiene standards (i.e. hand washing, the use of sanitisers, etc.).

An example of the positive response of church leaders, particularly of Pentecostal churches in Nigeria, is that of Pastor E.A. Adeboye, who serves as the head pastor of the Redeemed Christian

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Church of God (RCCG). In a recent online church broadcast, Adeboye argued that the spread of the pandemic is God's way of demonstrating his sovereignty over all human affairs; the pandemic's growing number of casualties from all walks of life, implies that no one, irrespective of one's socio-economic standing in society, is safe from the virus's potentially fatal grasp. Adeboye's "rhetoric about COVID-19 provides an important illustration of how Pentecostal theology and Christian eschatology inform how Nigerian Pentecostals understand the pandemic's global imposition" (Wadibia, 2020). Adeboye draws attention to the notion that no one is safe from contracting the virus regardless of social position. In Nigeria, a country rife with psychologically ingrained ecosystems of socio-cultural hierarchies, Adeboye's argument underscores the helplessness that all Nigerians face when dealing with an enemy like COVID-19. Citing the biblical story of Job, Adeboye articulates a view that God allows some editions of evil to persist, as opposed to the view that all evil originates from Satan, to usher individuals and societies into a novel understanding of his providential sovereignty. Ultimately, Adeboye concludes by asserting that true Christians are safe from the clutches of COVID-19. In quoting Psalm 91, which directly correlates identifying as a Christian benefitting from God's protection, Adeboye situates his understanding of the pandemic's spread on a playing field that straddles between the material and ethereal realms (Wadibia, 2020).

Similarly, Pastor Tunde Bakare, head of the Latter Rain Assembly Church, rebuked religious leaders calling for a reopening of prayer houses, especially in the case of organisations with extensive facilities. In his own words, Bakare stated that "instead of criticising the government, they should collaborate with them; they must be prepared to offer some of their halls for the government to use as isolation centres" (Olukoya and Mohammed, 2020)

Most Muslims also accepted the lockdown as part of the safety and control measures of the spread of the COVID-19 pandemic. A typical example of such Muslims includes journalist Baballe Mukhtari, who agrees with the confinement rules, even if they have deeply affected their lives. Mukhtari expressed his happiness for being with his family due to the lockdown, to which he alluded to his health and family safety. He said that even though he did not go to the mosque, he enjoyed prayers at home, at least for the moment of the pandemic (Olukoya and Mohammed, 2020).

On the flip side of the reality of the COVID-19 pandemic in Nigeria are some clerics who dismissed the existence of the disease with a wave of a hand. Onapajo and Adebisi (2020) have given a critical insight into some of the vituperations of some church leaders against lockdown. The authors reported Nigerians as renowned for their religiosity. They thus corroborated a "2018 Global Attitudes Survey by the Pew Research Center", which estimated that 65% of the Nigerian population specified that religion plays a focal role in their country, with 96% pinpointing religion as the essential factor in their lives. Onapajo and Adebisi (2020) reiterated that this religious disposition of Nigerians explains why, when COVID-19 broke out in Wuhan, many Nigerians responded in religious parlance of exclamations such as, 'it is not my portion!' or that they are immune to COVID-19 because they are 'Children of God'—views, no doubt, inspired by the repudiation of Coronavirus by some Nigerian religious leaders.

The above authors cited three typical examples of the pessimists or rebuttal perspective that portrays COVID-19 as a hoax. The authors reported a widely circulated video of a church service



in Abia State, where Pastor Innocent Kingsley, the General Overseer of Bible-Believing Mission, dismissed the existence of COVID-19 in Nigeria. Assuredly, he proclaimed:

‘That thing cannot survive in Nigeria. What do you mean by Coronavirus when there is corrosive anointing? It can’t survive here. I don’t know about other places. There is no Coronavirus here. Coronavirus does not exist in Nigeria.’ To many ovations from his church members, he added, ‘how can it survive here, Coronavirus against corrosive anointing? It can’t survive here. It is not possible. It doesn’t exist in Nigeria. I am being very sincere with you; it is not in Nigeria. Coronavirus hasn’t entered Nigeria yet’ (Onapajo and Adebisi, 2020).

The authors further reported:

In another viral video, Prophet Dr David Kingleo Elijah, the General Overseer of Mount of Possibility Church, Ojo, Lagos, also proclaimed to his congregation that he would travel to China to use his spiritual healing prowess to ‘prophetically destroy Coronavirus’. Pompously, he declared, ‘where there is a prophet, people will not die. I am a prophet. I cannot be a prophet, I am in this world, and China is dying. It is not possible.’ Two ‘medical professionals’ also shared a testimony confirming the ability of Pastor David Ibiyeomie (of Salvation Ministries) to prevent the Coronavirus from infesting whoever seeks his healing powers. The testifying duo claimed to be the first medical personnel to contact a patient of COVID-19 in Nigeria. They stated that the prayers and Holy Communion ministered by Pastor Ibiyeomie during their isolation time saved them from being infected by the deadly virus (Onapajo and Adebisi, 2020).

A report was also made of a similar reaction by Bishop Oyedepo (following the Ebola outbreak in August 2014), where he proclaimed to his congregation: ‘Ebola knows it cannot come near where I stay. Can Ebola access Jesus? Science is eternally inferior to scriptures, and every man is a victim of his fear.’ He concluded that Ebola ‘is not a parasite; it is an attack of the devil. By the blood of Jesus, Africa is delivered from Ebola.’

Reacting to the government’s directive shutting down all religious and worship centres, Bishop Oyedepo averred:

Shutting down churches would be like shutting down hospitals. There are churches today where you sit down, and you are healed. Many are around the world. A family of four ravaged by tuberculosis sat down in this church. They carried them here. Family members have left them alone. And for 30 minutes, the husband looked at the wife, and the wife looked at the husband and said, “This cough fears God.” It ended there. The four were healed at the same time. That means that the sickness is pure oppression of the devil, which no hospitals have an answer to. Many, many illnesses would have no medical solution but prayers in church’ (Onapajo and Adebisi, 2020)

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Muslims, on the other hand, also responded to the closure of religious centres. While the Nigerian Supreme Council for Islamic Affairs (NSCIA) urged Muslims to comply with the ban on congregational prayers, some Muslim leaders continued to share misinformation that Muslims are “immune” to contagious disease. A typical example of negative response from Muslim clerics was the reaction of an Islamic scholar, Abubakr Imam Ali-agan, who on March 18, 2020, warned President Muhammadu Buhari’s government, the Sultanate Council and Muslim authorities not to shut down mosques in Nigeria, claiming that Muslims “have already been endowed with natural immunity to the virus” (Lichtenstein, Ajayi and Egbunike, 2020).

The ban on religious gatherings drew the ire of some mosque leaders who are among the vocal minority that rejected the coronavirus lockdown. As reported by Aliyu Tilde, “People have a strong attachment to religion.” Muslims felt threatened by perceived attempts by secular powers to regulate their religion, and some even assume the lockdown to be a conspiracy to prevent Muslims from praying and worshipping. Some who reacted angrily to government lockdown directives were from hard-hit regions, such as Kano – a predominantly Muslim city in the country’s north. Thus, to press down their directives and ensure compliance, pockets of resistance led to the suspension of several Imams for violating state-imposed measures to slow down the spread of COVID-19 in Nigeria (Olukoya and Mohammed, 2020).

### **The impact of perceptions and responses of religious groups on the National COVID-19 Response Strategy**

As observed earlier in the study, there are two sides to the conceptions on COVID-19 among religious leaders in Nigeria. These conceptions inadvertently impacted the national COVID-19 strategy differently. This is quite critical because Nigeria is a country where it is estimated that there are 41 million non-literate adults and a limited number of people with access to the internet (estimated at 92 million only). In such a country, religious leaders account for a crucial source of information dissemination even as there are more places of worship than schools. Coupled with the citizens’ lack of trust in the political class, people are more inclined to listen to and believe the views of their religious leaders as very essential to them. (Ayeni, 2020).

In essence, whatever is the opinion of the religious leaders concerning Coronavirus becomes the creed and attitude of most of their members. To a large extent, this extended to a chunk of the population. Thus, citizens’ compliances with NCDC directives were largely dependent on the psychological meandering of religious leaders. The truth is that those religious leaders who were positively disposed to the NCDC/PTF social distancing rules and hygiene measures queued into it supported the national COVID-19 strategy. Such leaders encouraged their members to comply with the safety rules. At the same time, those with spurious misconceptions negatively impacted the national COVID-19 strategy because they led the people into misconstruing the COVID-19 disease and safety measures and misled them into disregarding government directives issued to mitigate the disease.

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Examples of religious leaders with large religious congregations who showed a positive disposition toward the national strategy against the pandemic included, but not limited to, Pastor Enoch Adeboye, who oversees a church with over five million members, began social distancing in his church even before the government started implementing its orders. Thus, during the actual lockdown, the church directed all its branches to hold online services. Similarly, Sam Adeyemi, the Senior Pastor of Daystar Church and various other churches, had online services (Ayeni, 2020).

Also supportive of the national COVID-19 strategy was the Council of Imams and Ulama, Kaduna State Chapter, which suspended the congregational Friday and daily prayers. The Council directed that not more than 20 congregants be permitted in a service. This was to be sustained until further directives came from the NCDC, the Council warned. The Kogi State chapter of the Council followed suit and suspended prayers. Likewise, other supportive Muslim congregations throughout the country followed suit. (The Africa Report, 2020).

However, contrary to the above, some churches, such as Winners Church and COZA, and their leaders, such as Pastor Paul Enenche of Dunamis International Church in Abuja, held some misgivings and scepticisms about the reality of COVID-19, and went on with regular church services. Of particular note is Dunamis International Church in Abuja, which held regular service at its 100,000 capacity auditorium (Ayeni, 2020).

The point of emphasis is that the perceptions of the religious leaders directly or indirectly affected the implementation of the national COVID-19 protocols and directives. As we saw in the preceding section, those who believed in the lethal reality of the Coronavirus complied with the safety measures of the government and persuaded their members to stay safe, and by so doing, supported the national COVID-19 strategy. On the contrary, those with misconceptions, particularly holding on to one of the conspiracy theories or the other (or spurious superstition), did not initially comply with NCDC/PTF safety rules and indoctrinated their members not to abide by the COVID-19 safety measures and government directives. Such religious leaders were only forced to observe the lockdown measures, and they did not compel their followers to adhere to government restriction orders. Attitudes of this kind, no doubt, may have contributed to the spread of the disease in the community. Therefore, it is not out of place to state here that the bulk of the violation of the NCDC/PTF COVID-19 protocols sprang from these religious adherents whose leaders had indoctrinated them to believe that the disease is a hoax. This attitude of theirs cannot be said to support the national strategy, but rather an obstacle that complicates issues for the government in terms of spending more on security agencies to effect compliance by breakers. Therefore, one could firmly posit that the burden of containing the spread of the COVID-19 disease would have been lighter and more effective if all religious leaders were on the same page with the government. The dissenting misconceptions added to the problem.

If not for any other thing, although every night around 11:30 pm, the Nigeria Centre for Disease Control (NCDC) publishes daily figures for COVID-19 confirmed cases, as well as the number of patients discharged, comments under the nightly tweet at the peak of the pandemic, showed what many described the figures generated by the NCDC as estimates.

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A good many Nigerians only began to gradually believe in the existence of the virus as it continued to spread, and notable Nigerians began dying as a result. Therefore, before the positive change of attitudes by Nigerians on the adverse effects of COVID-19, the damage has already been done. Hence, we firmly believe that amidst the several attempts to address COVID-19 misinformation in Nigeria, a wide gap still exists in knowledge and understanding by citizens on the realities of the disease. The fact that the NCDC has used its social media platforms to debunk misinformation and issue press releases to correct misgivings is laudable (Adepoju, 2020). However, a lot still needs to be done through religious leaders as they are believed to constitute a greater force in the joint struggle to eradicate the disease. Because religious leaders essentially created the misgivings, it must be saddled on them to reverse such reservations.

### **Coping mechanisms**

To avoid the community spread of the disease, the churches and mosques devised creative ways to adapt and cope with the hardships occasioned by the COVID-19 lockdowns and ban on mass gatherings in their places of worship. Thus, in response to the federal government's insistence that no public meeting seats an audience of more than 50 people, several of Nigeria's Pentecostal churches moved their services online. These are not without exceptions, as some refused to adapt to change. (Wadibia, 2020).

A comparative quantitative study carried out by Afolaranmi (2020) regarding church activities before and during the lockdown, through a questionnaire, revealed the following:

#### **A. Major church activities before the COVID-19 lockdown in Nigeria**

- Symposia
- Recording of audio and visual messages
- Drama or short playlets
- Sports
- Vigil sessions
- Retreat sessions
- Physical presence at members' functions
- Training sessions
- Home caring ministry to the elderly
- Letter writing
- Classroom activities
- Writing religious materials
- Seminars
- Missions trips/outreaches
- Telephone calls
- Text message (SMS)
- Visitation

- Discipleship programs
- Counselling
- Open-air services/revival
- One-on-one discussion
- Evangelism
- House fellowship/Cell-group sessions
- Prayer from the pulpit
- Printing of religious literature
- Bible study and teaching sessions
- Use of social media and other internet tools
- Use of some technological tools
- Preaching from the pulpit
- Regular church activities

From the above report, though the churches engaged its members in using some information technology tools such as telephone calls, text messages, use of social media and other internet tools, the majority of other engagements and activities revolved around personal contacts and mass gatherings.

## **B. Major Church Activities during the COVID-19 Lockdown in Nigeria**

- Use of social media platforms for communication and live streaming (WhatsApp groups, Facebook, Youtube, Telegram messenger) House fellowship/House cell church
- Telephone (for counselling and prayers)
- Zoom
- Text message (SMS)
- Sunday service online
- Email
- Teleconference
- Recorded messages and songs
- Weekly radio broadcast
- Multiple number of services per Sunday
- Conference call
- Visitation
- Online prayers sessions
- Family fellowship
- Typing of messages
- Website posting
- Personal counselling (for a few emergencies)
- Twitter
- Instagram
- Video recording
- Physical ministration
- Internet radio

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- Transferable videos, audio and text
  - Webinar
  - Imo messenger
  - Distribution of relief packages
  - Print media
  - Use of Google forms
  - Online class sessions
  - Sharing of God's word early in the morning
  - Television (televangelism)
  - Paying tithe through online banking transfer
  - Google classroom (Afolaranmi, 2020).

From the above coping mechanisms during the COVID-19 lockdown in Nigeria, it is clear that there is less physical contact but more and creative information technology-driven church activities. More churches that had not accessed the opportunities offered by the internet quickly adjusted and adapted it as a part of coping measures. In a way, the lockdown though abnormal helped raise internet awareness and adaptability by churches moving them away from solely traditional mass social gatherings. Thus, it is not out of place to point out clearly that COVID-19 pandemic lockdown of religious gatherings, apart from the conventional means of pastoral ministry, created various aspects of internet ministry that took a front row in worshipping and evangelistic activities, which were hitherto relegated.

## Conclusion

The study examined the intricate link between the conception of Nigerian religious clerics and their responses to COVID-19 lockdowns, safety rules and palliative measures. It analysed conspiracy theory and how their acceptance or rejection influenced religious leaders' COVID-19 responses and coping mechanisms. During the study, it was established that the prominent religious leaders, associations and groups responded well to COVID-19 protocols and, as well, subscribed to government orders and directives regarding containing the pandemic. This situation may have warranted the COVID-19 sceptics to readjust their psychology to accept the reality of the pandemic. To the group of sceptics and pessimists, the lockdown appeared a bitter pill forced down their throats. Hence, they could manufacture any opposing theory to justify their fear and disbelief to the fact that there could be a time when a mere virus could lead to placing a ban on religious gatherings and worships. Be that as it may, despite their unrelenting rejection and resistance to the realities of the existence of the pandemic and government safety directives, the sceptics were, however, compelled to observe the lockdown procedures. The study further revealed that the coping mechanisms applied by religious bodies resulted in the creative use of and adaptation to internet-related communication gadgets, which were scarcely used in the pre-COVID-19 eras. Even when some procured such facilities, they seldom used them because they preferred mass gathering and social contact procedures, which brought social bonding among members. However, with the COVID-19 lockdown, the religious worship centres devised means of effectively deploying and utilising information technology to keep members connected in the face

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of social restrictions. The study observed that the lockdown, as imposed by the government, was incapable of wiping away the social cord that bound members of religious organisations together (as they were able to cope with the absence of physical gathering and bonding through spiritual routines like communion service, physical corporate worship and prayers, hugging, shaking of hands, anointing, and sometimes kissing as a sign of love and unity). Therefore, our investigation shows no over-estimating of the importance of religious organisations and leaders and the roles they play in the effective functioning of government in a country like Nigeria.

From the suggestive potentials of this study, we recommend, among others, that the government begins to consider it a matter of necessity to work in synergy with religious leaders and religious bodies if it must realise its goal of national stability, cohesion and development. It is crucial to suggest that the government begin to open avenues to train these leaders and the management of the religious bodies on the internet and ICT knowledge acquisition to make them compliant with today's realities. The government can achieve this by opening ICT centres that train such leaders at very subsidized rates. Beyond the above, the government must ensure that such bodies and leaders, who wish to key into the mass media for evangelism, are not charged unduly for their programs.

To achieve the above, it would suffice to suggest that the government establish not just a ministry but a commission that will oversee the activities of these religious bodies and their leaders by making sure their teachings and activities fall within the ambit of extant laws of the land. In our opinion, therefore, whenever there is a pandemic of this magnitude, both the government and religious organisations should unite in one accord to ensure an enduring solution is found through the provision of the best practices of safety and hygiene protocols to contain the casualty rate and risks of contraction. It should not be out of place to state here that the initial denial, rejection, and conspiracy theories of some religious leaders with large followers may have arisen due to the distrust citizens have of their leaders. The government needs to prepare itself ahead of unforeseen events such as the COVID-19 pandemic. Needless to repeat, both the federal government and its units were not prepared for a pandemic such as the COVID-19. The underfunding of the health sector by the government created a lack of trust in the ability of the government to provide a cure for victims of the pandemic. Thus, instead of submitting themselves to isolation centres, citizens who contracted the disease preferred going to their spiritual directors for the cure. The result of this unpreparedness was the rejection of authority by citizens, as witnessed during the lockdown. Thus, investment in the health sector and adequate remuneration and protection of health workers is needed here. Again, unlike what was obtained in the developed countries of the West, Asia and America, the Nigerian government was incapable of providing adequate economic protections to Nigerians. This made the people disregard the restriction orders as they fended for themselves. Government must begin to look towards the direction of provision of good welfare packages for its citizens. More so, the failure of the government to have a disciplined military and security personnel compounded the spread. Thus, security agents saw the period as an opportunity to make money. During lockdowns, such security personnel extorted citizens by taking bribes and permitting them passages to restricted places. If the government improves on these areas of lack and inadequacies, a lot would be done to turn things around for the good of all.

## About the Author

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# Rethinking the Securitization of Public Health in Africa: A Frame of Reference

Abdou Rahim Lema and Lukmon Akintola

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## Abstract

Drawing from the growing literature on the securitisation of public health in general and, in particular, that of infectious diseases in Africa, this paper explores the process through which certain health issues are perceived as security and existential threats. It uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health in the African continent and its implications before presenting a frame of reference, a better and more constructive way of strengthening health systems in the continent.

## Keywords

COVID-19, securitization, public health, healthcare, Africa

## Introduction

The end of the Cold War and its power politics has significantly opened up the space on security agendas to allow the inclusion of issues such as infectious diseases<sup>1</sup>. According to Rushton (2014), such opening up has led to recent changes in how policymakers perceive and deal with public health crises. The result has been a growing convergence of public health policymakers and those in foreign policy and security sectors towards perceiving and reacting to public health crises as security threats (Fidler, 2007; Eroukhmanoff, 2018). Hence, notwithstanding calls for caution, the health-security nexus has grown to become a dominant paradigm in recent years (Burci, 2014).

Drawing from the growing literature on the securitisation of public health in general and, in particular, that of infectious diseases in Africa, this paper explores the process through which

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<sup>1</sup> However, it is worth noting that some researchers trace this process of 'opening up' the security space back to the adoption of the Biological Weapons Convention in the 1970s, as it framed infectious diseases as a security issue and began to blur the lines between infectious diseases as public health threats and security threats. See, for instance, Kelle (2007).

certain health issues—particularly infectious diseases—are perceived<sup>2</sup> as security and existential threats that call for actions outside the normal and regular bounds of political processes and procedures (Buzan, Wæver, & de Wilde 1998). It uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health in the African continent and its implications. It also presents a frame of reference, a better and more constructive way of *strengthening* public health systems in the continent.

As Elbe & Voelkner (2014) observe, securitisation theory is primarily concerned with understanding how specific issues draw different responses in national and international policy circles once they become widely perceived or presented as pressing existential threats. Drawing from several empirical examples in African countries, we examine the implications of securitisation for the continent. Following Elbe & Voelkner (2014), the empirical materials for the study are drawn from a variety of sources. And though particular attention is given to those dealing with the securitisation of public health in Africa, materials covering other regions have also been useful in allowing comparisons.

The remainder of the paper is structured as follows. We first cover the conceptual and theoretical discussions on the securitisation of public health. We then move on to briefly survey some of the existing literature<sup>3</sup> to analyse the general implications of securitising public health before zooming in on the specific and contextualised impact for Africa. The analysis in this part looks at the effects of securitising public health in the African context and draws empirical evidence from several examples in African countries. Before concluding, we present a detailed discussion on our suggested frame of reference that offers a more constructive way of *strengthening* public health systems throughout the continent. The paper mainly calls for, and this is our central argument, the urgent adoption of people-centred approaches to better address health and other crises across the continent more inclusively and sustainably. It concludes by making the case that effective public health could help African countries deal with the multiple layers of fragility facing them.

## Theoretical and conceptual discussions

The theory of securitisation emerged as a reaction to the mainstream International Relations (IR) theories that have dominated the field until the end of the Cold War. While major IR theories such as realism take ‘security’ for granted, securitisation theorists posit that security threat is not an objective condition independent of the person who perceives and represents it. That is, following Alexander Wendt (1995) ‘s logic, security is what we make of it: Securitisation is the

2 The conceptualization is in line with the original presentation of ‘securitisation’ processes provided by Buzan and colleagues, and we adopt it for this work in the specific context of the nexus between health and security. But it is important to note and recognize that, while such definition is popular in international relations scholarship, it is generally considered ‘overbearing’ or ‘overstretched’ in the global health space. For example, in an article tracing the process of linking health and security, Wenham (2019) argues that “the discourse of global health security has become close to synonymous with global health, their meanings being considered almost interchangeable”, leading to path dependencies and altering the global health security narrative.

3 It should be noted that, due to the limited time and space at our disposal, it is impossible to provide an exhaustive review of this rich and wide-ranging literature. We sincerely thank the anonymous reviewer for bringing this to our attention.

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discursive process through which an issue is socially constructed as a security threat through “speech act”<sup>4</sup> by relevant political actors (Buzan, Wæver, and de Wilde 1998; Eroukmanoff, 2018). By successfully labelling an event as a ‘security’ threat, the relevant political actors convey a sense of threat that calls for measures outside the regular bounds of political procedures. In that sense, Giorgio Agamben’s description of “the state of exception”<sup>5</sup> effectively applies to the securitisation process whereby an event gains saliency and prioritisation on political agendas.

In the context of public health, securitisation refers to the discursive process by which public health issues are perceived and framed as security threats, elevating them from technical public health issues which could be dealt with through routine procedures of public health institutions and scientific expertise to something perceived as posing a much more existential threat and, therefore, requiring immediate and more forceful measures (see Burci, 2014; Elbe & Voelkner, 2014). In that sense, securitising public health involves identifying and declaring a particular health issue as an existential security threat. There are plenty of historical examples illustrating such securitisation moves.

On September 18, 2014, the United Nations Security Council (UNSC) declared that the Ebola outbreak in three West African countries—Guinea, Liberia, and Sierra Leone—constituted “a threat to international peace and security” (UNSC 2014). As Enemark (2017) pinpoints, the declaration was the first time a disease outbreak of natural origin was explicitly described using a language usually applied to political violence. Nonetheless, it is worth noting that already in 2000, HIV/AIDS was also recognised by the UNSC’s “Resolution 1308” as a threat to international security (Jin & Karackattu, 2011). Quite remarkably, however, not only was the language used then significantly less dramatic, but the focus was also primarily on the impact of HIV/AIDS on peacekeeping operations in Africa. In that regard and irrespective of its original intent, the UNSC’s resolution on Ebola was unprecedented in describing a naturally occurring disease outbreak using a language ordinarily applied to politically motivated violent conflicts (Enemark, 2017). More recently, the African Union’s Peace and Security Council warned on February 13, 2020, that the COVID-19 outbreak “could constitute a threat to peace and security in the [African] continent.”<sup>6</sup>

According to Burci (2014), it should not be surprising that public health challenges “would appear on the agenda of the [UNSC] given the increasing perception that the spread of infectious diseases [...] could threaten regional and global security.” More specifically, these concerns mainly

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4 According to Buzan and colleagues, “speech act” involves threats and vulnerabilities which are mainly “staged as existential threats to a referent object by a securitizing actor who thereby generates endorsement of emergency measures beyond rules that would otherwise bind” (Buzan, Wæver, and de Wilde 1998, p.5; emphasis added).

5 According to Giorgio Agamben, “the state of exception” refers to the ways an issue is dealt with through measures that circumvent normal legal procedures, for instance, by declaring a state of emergency to help justify the suspension of laws, only for them to become “a prolonged state of being.” Also, see Raulff (2004).

6 See <https://reliefweb.int/report/world/910th-meeting-au-peace-and-security-council-psc-ebola-and-coronavirus-outbreak-africa>

focus on the potential effects of infectious diseases on the stability of the affected countries<sup>7</sup>, their potential regional spillover, and the potential risk of international spread.

## Securitisation of public health: A critical analysis

A careful analysis of the extensive literature on securitisation reveals a wide range of arguments put forward to either defend or critique the growing efforts to securitise public health issues. This section first examines the leading ideas to support securitising public health before turning to the major criticisms of such securitisation efforts. We close the section with a summary table to synthesize the analysis.

### Arguments for securitising public health

The securitisation of public health appears appealing for some reasons, including the fact that security actors have a crucial role to play in protecting their populations from disease; that disease events can have widespread and devastating political, social, and economic effects<sup>8</sup>; that there are areas in which the security and public health communities can work together constructively; and that securitisation offers those in public health an opportunity to gain increased attention and much-needed resources for otherwise neglected health issues (Rushton, 2014). Moreover, Enermark (2010) emphasizes the significant role of policy measures under the Biological Weapons Convention (BWC), often used to address naturally occurring infectious diseases and the traditional concerns about possible weaponisation of pathogenic microorganisms.

As such, successfully securitising a particular health issue may help raise its status on political agendas by persuading governments to devote considerable attention and resources to tackle it. Accordingly, the issue may transcend “normal politics” to become “so important that it should not be exposed to the normal haggling of politics” (Buzan *et al.*, 1998). This is especially true where such crises lead to a state of emergencies and constant executive orders, whereby “the worlds of health and security collide inescapably” (Elbe, 2011; see also Fidler, 2007).

In addition to helping mobilise the needed resources, other benefits of securitisation include instituting and enforcing hygienic practices and behaviours, actively promoting more public awareness, and preventing panic and social instability (Wishnick, 2010). In that regard, securitisation of health is therefore perceived as hedging against the potentially dramatic consequences of highly pathogenic infectious diseases (Burci, 2014).

<sup>7</sup> These concerns are even greater when the outbreak hits conflict-ridden regions where state authorities are mistrusted and militias commit violent acts. This already difficult security situation would likely magnify the challenges of dealing with the health crisis, further disrupting public order, challenging the delivery of health care, and affecting disease control measures (Burci, 2014).

<sup>8</sup> It is not hard to imagine how severe outbreaks of infectious disease could significantly threaten both the ability and viability of the state to operate effectively (Rushton, 2014). See Gulati & Voss (2019, p.3) for analyses on the consequences of HIV/AIDS in the seriously affected regions of Africa. For further analyses on the potential widespread political, social, and economic effects of infectious diseases more broadly in Africa, see Chan (2014), Enermark (2017), BBC (2014), Nossiter (2014), Garrett (2005), etc.

Finally, the “synergy thesis”, discussed by David Fidler (2007), maintains that the first line of defence is usually the public health system when an outbreak of infectious disease occurs. At its core, securitisation thus helps strengthen the public health system, allowing for achieving the dual purpose of defending against biological weapons and naturally occurring diseases<sup>9</sup>. Also, since the security and defence sectors usually attract a larger share of national budgets, securitisation of health allows decision-makers to redirect these resources toward reinforcing public health capabilities in times of crisis (Burci, 2014; Davies, 2010). As such, it is contended, “[bio]security has elevated public health from the margins of ‘low politics’ to a seat at the table of the ‘high politics’ of national security...” (Fidler, 2007). These advantages notwithstanding, there are significant concerns with the surging moves towards securitising public health crises.

### Arguments against securitising public health

To begin with, securitising health challenges may, in some cases, lead to subordinating public health to scrupulous security agendas by dramatising the threats they pose. Moreover, the (over)reactive mobilisation involved in securitising a health crisis and the implied right to use extraordinary means to fence off the existential threat run counter to the preventive risk management strategies required to effectively address infectious diseases (Wishnick, 2010; Jin & Karackattu, 2011; Nunes, 2017).

Furthermore, Jin & Karackattu (2011) and Honigsbaum (2017) make the case that the dramatic moves to securitise health issues are often not motivated by the concerns or sympathy for the affected and most vulnerable populations. Instead, securitisation is primarily meant to protect more powerful countries. Ultimately, this gives credence to the widespread suspicion that global health security prioritises measures designed to *contain* diseases within the developing world rather than actions that address their root causes, including dysfunctional national health systems, institutional neglect, and delays as well as fragmentations of global responses to disease outbreaks. As such, securitisation is a short-termist strategy. It focuses on developing surveillance systems to contain outbreaks when and where they occur, instead of tackling the underlying structural causes of epidemics rooted in the lack of access to healthcare and the underlying social, economic, and political determinants of health (Hofman & Au, (eds.), 2017; Honigsbaum, 2017).

Other major arguments against securitising health issues include the fact that securitisation can distort the global health agenda and lead to a narrow and disproportionate focus on certain types of health problems while ignoring others with equal or greater morbidity and mortality; undermine the traditional humanitarian orientation of public health; impact negatively on individual rights, particularly the rights of those infected with illnesses that make “security threats”; potentially undermine the global cooperation necessary to deal with infectious disease threats in a globalised world; facilitate corruption by skewing public spending toward inflated defence and security

<sup>9</sup> Indeed, according to Standley et al. (2015), the cooperative efforts on bio-engagement among many countries exist at the nexus between public health and security, whereby the efforts explicitly prioritize projects that aim to reduce “the potential for accidental or intentional misuse and/or release of dangerous biological agents” as well as to improve basic public health capacities/systems. This usually helps meet the priority areas of both donor and partner countries, in that case making it a win-win engagement.

budgets; etc. (see Aldis, 2008; Ingram, 2008; McInnes and Lee, 2006; Feldbaum *et al.*, 2006; Elbe 2006, 2009; Enemark, 2009; Burci, 2014; and Rushton, 2014).

Equally concerning is the fact that securitising health issues turns them into threats to existence and survival. Therefore, tackling health concerns requires exceptional and urgent measures “that would otherwise bind” (Buzan, Wæver, and de Wilde, 1998). The danger, however, is that they quite often escape democratic scrutiny due to their urgency. For that reason, it is fair to argue that securitisation threatens democracy and human rights, especially in countries where institutions are weak or almost nonexistent. Characterising health issues as security threats pushes civilian healthcare responses towards the military, law enforcement agencies, and intelligence organisations. The logical result of embracing the appeal of muscular responses is the adoption of authoritarian approaches and coercive measures that override freedoms and civil liberties, which can directly and easily turn securitisation into a pretext to trample on human rights violations and further stigmatise the most vulnerable (Burci, 2014; Huang, 2014). Similarly, the language of security used to characterise health crises can also be invoked to justify repugnant deeds and egregious abuses.

*Summary Table of the advantages and disadvantages of the securitisation of public health*

Advantages	Disadvantages
Preventing or limiting potentially devastating consequences (economic, social, political, etc.) of disease outbreaks;	Subordinating public health to scrupulous security agendas;
Providing the opportunity to raise the status of some health issues on political agendas and mobilise much-needed resources;	Dramatising the threat and spreading fear and anxiety;
Instituting and enforcing hygienic practices and behaviours;	Lacking required preventive management strategies for quality public health;
Actively promoting public awareness, etc.	Promoting containment rather than addressing root causes of disease outbreaks;
	Possibly distorting global health agenda and leading to a narrowed and disproportionate focus on specific health problems while ignoring others with equal or greater morbidity and mortality;
	Possibly undermining democratic procedures, overriding freedoms and civil liberties, and violating fundamental human rights, etc.

## **Analysing the Implications of Securitisation of Health Crisis in Africa**

In this section, we explore the implications of securitising government responses to health crises in Africa. We conclude that the securitisation of public health in the continent has mainly been counter-productive.

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As it did to other parts of the world, the outbreak of the COVID-19 pandemic threw African countries off-balance. The pandemic has disrupted Africa's overall political-economic configuration, with countries turning to hard-line policies and incurring significant economic losses (OECD, 2020). As they struggled to curb the spread of the virus, many African governments imposed nationwide lockdowns and night curfews. Moreover, some governments opted for militarised responses to COVID-19, treating the virus as a threat to national stability that, in many instances, legitimised the use of force and brutality against civilians to enforce containment and preventive measures (HRW, 2021; Africa News, 2020). These drastic measures have far-reaching consequences for the continent and its people, as the following discussion illustrates.

### **Securitisation of Public Health in Africa and Human Rights Abuses**

As mentioned earlier, health securitisation stresses the deliberate framing of a public health crisis as a threat to national and international peace and stability. Roberts (2019) rightly posits that labelling a public health crisis as a security threat creates a sense of urgency. Hodgson (2017) also notes that "health securitisation is often a successful strategy for generating interest in, and resources for, a specific health issue". With effective framing of health securitisation, policymakers find reasons to boycott existing democratic and institutional procedures, opening doors for blatant abuses of human rights.

The responses to the COVID-19 pandemic in some African countries have often involved the use of lethal force on civilians by law enforcement agencies to implement lockdown orders. Citizens' rights to freedom of movement and expression are thus brutally quelled, leaving some civilians dead and many more injured. In Rwanda, for instance, about 60,000 people were severely punished for either not wearing face masks outdoors or breaching curfews or for not observing the social distancing order (BBC, 2020). This illustrates the danger of securitising health during a crisis, especially in the context where governments lack the trust of their citizens, as is the case in virtually all African countries.

Police brutality may pose more threat to peoples' lives than the virus itself. In Nigeria, the police force has a notorious record of human rights abuses, brutality, and extra-judicial killing (Council of Foreign Relations, 2020). Unsurprisingly, it only got worse during this COVID-19 pandemic. Nigeria's National Human Rights Commission released a report on April 1, 2020, noting that 18 people were killed by the Nigerian police in the course of enforcing the lockdown rules, even though only 12 people had died of COVID-19 in Nigeria at the time (BBC, 2020; Foreign Policy, 2020; The Guardian, 2020).



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Kenya is another African country that recorded incidents of extra-judicial killing by the police while implementing the lockdown measures. A recent report from the Independent Policing Oversight Authority (IPOA) revealed that 15 deaths and 31 incidents were directly linked to actions of police officers during curfew enforcement in Kenya (Anadolu Agency, 2020). The report's central claim is that extra-judicial killing has eaten deep into the fabric of these countries, feeding into the concerns that, in their bid to appear resolute in dealing with the crisis, policymakers are not particularly investing their efforts in preserving human lives.

Things are not any better in South Africa either, where the government deployed over 3,000 soldiers to enforce lockdown rules. If anything, the surged cases of brutality by law enforcement agents in South Africa during the COVID-19 lockdown orders is just as worrisome as in other African countries. Data from the Independent Police Investigative Directorate (IPID) show that 376 cases of police brutality and ten deaths are directly linked to the lockdown enforcement (ISS, 2020; Knoetze, 2020; Ncube, 2020).

In a similar trend, at least 12 people were killed by the police in the bid to enforce the lockdown rules in Uganda. Nyeko (2020) confirmed that “security forces have been using COVID-19 and the measures put in place to prevent its spread as an excuse to violate human rights.” More worrisome still, public health securitisation can be used to legitimise racial exclusion (Roberts, 2019). As Ncube (2020) pithily puts it during a virtual forum on the South Africa police's long history of abuse and impunity, “it is evident that police brutality is real, but it disproportionately affects the poor and the people of colour, specifically, the blacks.”

As these empirical examples show, there is danger to securitising public health, as it places priority on militarised responses rather than effectively tackling the disease and improving people's well-being. Calain and Sa'da (2015) point out that securitisation of health by policymakers is mostly not out of concern for the people; rather, it is a concern for themselves and their interests. While this position might be debatable, killing and maiming civilians in the name of preventing the spread of a virus does not add up. However, these tragic abuses go beyond the COVID-19 pandemic as similar developments were also rampant during the Ebola outbreak of 2014-2016 (see Benton, 2017).

## **Failed efforts to build resilient public health systems**

It is beyond any doubt that the health systems in many African countries are very weak, clearly manifested by chronically understaffed health facilities, unmotivated and ill-equipped health workers, insufficient medical supplies, and delayed staff payment (McPake *et al.*, 2016). This situation is largely caused by political instability, corruption, limited budgeting, among others (Rowden, 2014; Kentikelenis *et al.*, 2015). African countries are ranked very low in the area of quality healthcare, and citizens' life expectancies across the continent are among the lowest in the world. For instance, the WHO's best healthcare system ranking for 2019 puts Nigeria at 73rd, while Algeria and Kenya ranked 68th and 70th, respectively (WHO, 2019). In 2015, Sierra Leone ranked 1st, Central African Republic 2nd, Chad 3rd, and Nigeria 4th highest in

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maternal mortality among 184 countries around the world (CIA, 2015). These facts underscore the fragility of the health systems in many African countries.

The state of the health systems becomes worse in the face of health emergencies such as the Ebola outbreak or the COVID-19 pandemic as it is quickly over-stretched. With the outbreak of Ebola in Sierra Leone, for instance, Philips (2017) notes that material goods, finances, and human resources were drawn from already fragile and undersupplied health services to cater for the Ebola response. Clinical staff moved to Ebola treatment centres where financial remuneration and infection protection materials were available. In Monrovia, an assessment done in 2015 revealed that the Ebola outbreak caused critical deficiencies in the implementation of infection prevention and control (IPC) in several health facilities (IPC Partners Mapping, 2014; Cooper, 2015)

Amidst the COVID-19 pandemic, local clinics in some countries were quick to reject patients in need of primary care, leading to an increase in casualties from other diseases (World Economic Forum, 2021). As mentioned earlier, securitising health raises the profile of a particular disease and downplays that of others which could be equally or even more deadly (Philips, 2017). As such, Roberts (2019) asserts that “securitising health crisis is usually at the detriment of primary healthcare that could prevent the outbreak of an epidemic in the first place.” This is evident in the early days of HIV/AIDS, as funding significantly increased from 6% of all global health aid in 1998 to roughly half the total health funding in 2007. An estimated 5.2 million people received antiviral treatment by 2008, but funding for health systems declined from 62% to 26% of total health aid as a result (Roberts, 2019).

It is worth noting, moreover, that securitising public health further creates “knock-on effects” on the health systems, with a given health crisis causing significant impacts on other health issues and disrupting peoples’ social lives (Helleringer and Noymer, 2015). With the Ebola outbreak, for instance, on average, hospital visits dropped by 54%, antenatal care by 59%, and vaccination rates by 30% in the affected countries (Leuenberger *et al.*, 2015; Van de Pas and Van Belle, 2015). Moreover, it was estimated that across the three most-affected countries in West Africa—Sierra Leone, Liberia and Guinea—several additional malaria fatalities (10,900) were recorded, almost equal to the number of Ebola fatalities (11,308) (Walker *et al.*, 2015). In Guinea alone, a study shows that the number of malaria deaths was almost certainly “likely to greatly exceed the number of deaths from Ebola virus disease” (Plucinski *et al.*, 2015).

### **Securitisation of health crisis, politics, corruption, and national interests**

Finally, it is imperative to note that securitisation might increase the complex entanglement between politics and health, with policymakers prioritising political gains over the welfare of the people. Fundamentally, in many African countries, like elsewhere around the world, securitising health is often used as a strategic tool to prioritise a health issue as a political agenda (Roberts, 2019). This is evident in recent outbreaks in Africa, as national governments hurriedly doll out state funds to address the COVID-19 pandemic and further request additional funds from international donors. Nigeria’s central bank, for instance, requested a \$2.7 billion stimulus from

the International Monetary Fund (IMF), yet there are allegations of massive corruption in the way the money is spent (Bloomberg, 2020). Similarly, Guinea Conakry requested financial assistance from the World Bank to assuage the economic impacts of the pandemic. But in an embarrassing response, the World Bank pointed out that the economic cost of Guinea's COVID-19 action plan was "overpriced and unrealistic".

## **Implications/Consequences of Public Health Securitization (PHS) in Africa**

In that sense, securitising health may easily open doors to corruption at all levels, as allocated funds may escape normal democratic scrutiny, and little or no accountability ensues. This is evident in the corruption cases in South Africa where government officials were accused of stealing a \$26.3 billion COVID-19 relief fund (Anadolu Agency, 2020). More apparent is that securitising health could permit carting away public funds meant for fundamental health infrastructure that could support the improvement of sanitation, health education, healthcare services to the people.

The concept of security is still deeply rooted in using military force to address health crises—causing an alarming paradox between health, as a challenge primarily affecting human security, and securitisation as a response grounded in state-centrism and overt militarisation (Robert, 2019). In this light, many African governments and far beyond still hold tight to the 'pax armamenta' approach; thus, prioritising armed force as the chief means to promote stability, even in time of health crisis. The deployment of 3,000 soldiers by the South African government to maintain lockdown order reflects this militarised thinking.

A 1994 report by the United Nations Development Programme (UNDP) on the *New Dimensions of Human Security* identified health as one of the major threats to human security, and clearly distinguished between the idea of human security - an individual, people-centred concept - and the more traditional state-centred concept of security. The report further pointed out that irrespective of the threat, people should be the primary concern of politicians and policymakers. African government should heed these calls. Unfortunately, securitising public health usually leads policymakers to overlook their responsibilities of building resilient healthcare systems and their accountability to the people (see the figure below).

## **Implications/consequences of public health securitization (PHS) in Africa**

### **PHS and Human Rights Abuses**

- Restrictions on civil liberties
- Brutality of law enforcement agencies
- Lack of democratic accountability
- Institutionalized harassment
- Extra-judicial killings
- Etc.

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## **PHS and Failed Health Systems**

- Weak and dysfunctional health systems
- Chronically understaffed healthcare facilities
- Unmotivated and ill-equipped health workers
- Insufficient medical supplies
- Etc.

## **PHS, Politics, Corruption, and National Interests**

- Dangerous entanglement between politics and health
- Lack of transparency and democratic accountability
- Skewed public spending
- Corruption
- Etc.

## **Frame of reference for strengthening public health systems in Africa**

This section presents the suggested frame of reference to make African health systems more resilient, effective, and people-oriented. As the illustrative figure at the end of the section shows, the frame of reference calls for a holistic and inclusive approach to healthcare.

One of the most troubling issues with the securitisation of public health challenges is the fact that it is always a reactive move, as opposed to adopting more proactive and sustainable measures that ensure state preparedness. This is especially true in the African continent where states generally lack both the resources and the capabilities to effectively deal with major disease outbreaks. To address this particular challenge and protect vulnerable populations, African countries would do better to intensify and accelerate their efforts and resources in outbreak preventions through capacity building and system reinforcement. Not only will such efforts be more sustainable; but they will also more effectively promote and protect health (Gulati & Voss, 2019). It is worth insisting, however, that these efforts should also take into account the two pillars of public health governance, namely, surveillance and intervention. A well-functioning health system should incorporate the two crucial pillars and ensure its ability to intervene to prevent, protect against, or respond to serious infectious disease outbreaks.

Likewise, though we recognise that the securitisation of health issues can be a useful move in generating interest and mobilising resources, we caution against its thoughtless implementation in the continent that often leads to misallocation of already scarce resources. Instead, to reduce the risk of outbreak and provide better healthcare, there is an urgent need to ensure that the mobilised resources help extend universal health coverage and improve the social determinants of health. There is little doubt that the effects of infectious diseases such as Ebola and HIV/AIDS have been disproportionately felt in many African countries due to a lack of adequate health infrastructure.

Rehabilitation and (re)construction efforts in these countries should be designed to move them in the direction of “healthy health systems” (Hofman & Au, 2017). But to achieve that goal, the concerned African countries and the international health community will need to proactively

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address the root causes of and the underlying conditions for their largely dysfunctional health systems. There is also a need for an informed scientific assessment of health risks that would take into consideration the local contexts to better help prevent disease outbreaks and build resilient and efficient health systems (Gulati & Voss, 2019).

Mistrust of state authority is another major issue African countries grapple with in dealing with the “unpredictable and unknowable” health emergencies (Honigsbaum, 2017). As Hofman & Au (2017) argue, the low levels of trust between the populations and public authorities have been playing a leading role in considerably weakening the ability of health actors to influence individual behaviour and effectively respond to health crises. This is well illustrated by the 2014-2016 Ebola crisis when the already weak health systems crumbled further from the added crises of trust. The current securitisation strategies of health crises, whereby security forces are deployed to enforce response measures, have heightened this trend in many African countries. In an analysis of the Ebola epidemic, Benton (2017) reports that although domestic security forces in the affected countries performed much-needed public health functions and helped enforce emergency measures, their implication in egregious abuses of power has ignited mistrust of state actors and policies related to Ebola prevention and treatment. As such, securitised public health efforts need to be coupled with provisions of care and comfort, especially to the needy and most vulnerable communities. Equally important is that these efforts should be implemented through inclusive and participatory dialogues. After all, public trust is crucial to successfully addressing any crisis, including that of health: “Trust is a necessary component of cooperation, and open communication is a necessary component of trust” (Philips, 2017).

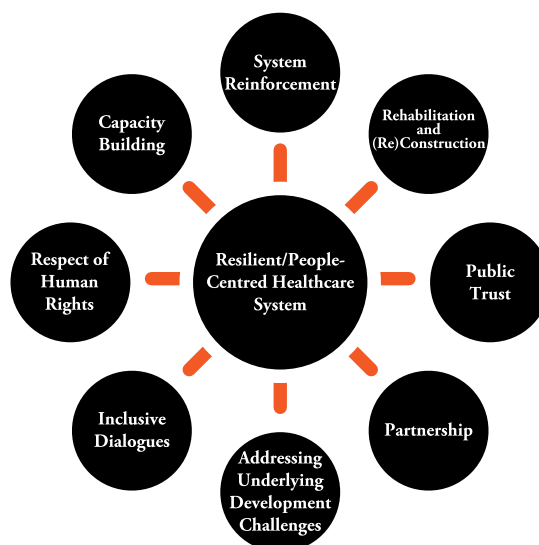
It is also worth remembering that outbreaks of infectious diseases expose people to direct risks of contamination and potential death as well as indirect risks of rising food insecurity and reduced livelihoods that prompt concerns that starvation would pose more of a danger than the disease itself, as well as increased mortality from other diseases as a result of the dysfunction of health systems. To be effective, response policies in Africa need to take into account these risks. Unfortunately, although it is clear that providing a safety net and livelihoods would do much to boost people’s trust in their respective governments, it is ignored all too often. Such a measure would also erase the need of deploying large contingents of armed forces to implement and enforce response measures, for the people will listen to the government response measures only when their basic needs and fundamental security are well taken care of.

Furthermore, contrary to the current securitisation strategies that solely focus on the treatment and containment of infectious diseases, more sustainable solutions through building resilient, well-functioning, and accessible health systems must be implemented (see figure below). This fosters the implementation of human right to health, creates trust in state structures, and takes into account the security of the general population (Gulati & Voss, 2019). It also takes into account the need to promote peace and stability through accessible health in Africa, including support for healthy living conditions, preventive measures, detection and treatment of acute and chronic diseases, as well as rehabilitation where and whenever the need arises. The ultimate goal should be to establish and sustain resilient, accessible, and well-equipped health systems that care for people’s needs and prevent, detect, and respond to infectious diseases while also paying greater

attention to the social function of the health sector as a stabilising factor (Gulati & Voss, 2019). Achieving this will effectively align African health systems with the global recognition that the health of all peoples is a fundamental factor to the attainment of peace and security.

As mentioned earlier, there is a consensus that disease outbreaks expose and exploit the vulnerabilities of health systems. In Africa, where flexibility and adaptability of health mechanisms remain distant aspirations, the already poor health systems deteriorate even further in the wake of a major disease outbreak. Underlying this is a combination of political instability, budget limitations, restricted fiscal space as well as the effect of major outbreaks such as Ebola and COVID-19 (Rowden, 2014; Kentikelenis *et al.*, 2015; and Philips, 2017). Thus, improving the health and well-being of the populations through preparedness to minimise the “knock-on effects”<sup>10</sup> (both direct and indirect) of disease outbreaks on health systems becomes imperative (Philips, 2017). Despite Philips (2017) ‘s scepticism<sup>11</sup>, in the resilience of African health systems, “the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganise if conditions require it” (Kruk *et al.*, 2015), is what is urgently needed. Resilience, in the African context where health systems face problems and challenges left ignored for too long, requires (re) building healthy health ecosystems and adopting a “multi-sectoral integrated approach, one that equips countries to absorb unforeseen severe shocks” (Kieny and Dovlo, 2015). In a nutshell, while it is a useful tactic for resource mobilisation and for building momentum to tackle health challenges, securitisation alone will be insufficient in helping Africa’s health systems function better. Thus, mobilisation efforts must be coupled with well-thought-out and flexible planning that reflects on needs and priorities.

### A Frame of Reference for Strengthening Public Health in Africa



<sup>10</sup> According to Philips (2017) “the majority of people who died during the Ebola epidemic [of 2014-2016] died of something other than Ebola. Many of these deaths were indirectly caused by the crisis.”

<sup>11</sup> A major “problem with the concept of resilience,” Philips (2017) argues, “is that it frames health response on risk rather than need; it is about future strength rather than current vulnerabilities.” But it also “de-emphasizes the immediate problems faced by a society for a focus on mitigating against future, potential shocks.”

## Conclusion

Drawing from the vast body of literature on the securitisation of public health in general and, in particular, the securitisation of infectious diseases in Africa, this paper offers an analysis of the process through which certain health issues—particularly infectious diseases—are perceived as security and existential threats. The paper uses securitisation theory as its theoretical and conceptual foundation to offer a critical analysis of the securitisation of public health crises in the African continent and its implications before presenting a frame of reference, a better and more constructive way of *strengthening* public health systems in the continent. Overall, the paper contributes to the growing body of literature on health securitisation in Africa and could inform policymakers—and other relevant stakeholders—on how to better address public health challenges facing African countries.

Thus, although the securitisation of health can be a useful tactic for generating interest and resources for African governments, our analysis shows that there are a variety of problems associated with it and, therefore, it should be adopted with much caution and more responsibly. The frame of reference we detailed above shows how this can be done. It calls for prioritising the health and well-being of the people (people-centred approach to health) and ensuring that necessary mechanisms are in place to make healthcare a leading factor to Africa's stability, peace, prosperity, and development. Essentially, it could help break the chain of Africa's cycles of fragility. As such, the proposed frame of reference can be a vital tool to prevent the misallocation of scarce resources that undermines efforts to extend universal health coverage in the continent. Equally important, it can help improve the social determinants of people's health while ensuring resilience against and preparedness of healthcare mechanisms for potential future crises.

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