Africa, COVID-19 and Responsibility

By:

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The coronavirus disease (COVID-19) has inverted stereotypical colonial narratives of disease directionality. How could it possibly be that Europe and the United States are the pandemic epicenters? How could "shit-hole countries" in the Global South impose travel bans on passengers from these areas? Before the first reported case on the African continent, several media outlets demanded to know *why* Africans were not presenting with the coronavirus disease.

The impact of COVID-19 is still very much evolving on the African continent as countries have thus far been spared the worst of the pandemic. The United Nations Economic Commission for Africa released a recent report indicating that anywhere between 300,000 and 3.3 million African people could lose their lives as a direct result of COVID-19, depending on the intervention measures taken to stop the spread. The latest Africa Centres for Disease Control and Prevention numbers reveal that 64,214 COVID-19 cases are confirmed across

the continent with 2,293 deaths and 22,243 recoveries. These numbers are of course, only reflective of the robustness of testing regimes rather than the actual number of infections. Yet, they provide some indication that thus far, most of the cases are geographically clustered in South Africa or in North African countries like Algeria, Egypt and Morocco. All these countries report over 5,000 cases as of May 11, 2020 with South Africa and Egypt reporting the highest numbers.

This post analyzes the potential impact of COVID-19 on the African continent given systemic healthcare vulnerabilities and the need for contextualized containment strategies. It examines the historical role of international financial institutions in limiting domestic health spending and capacity. This post also delves into re-conceptualizing responsibility for pandemic and epidemic diseases.

There is cause for genuine anxiety about the trajectory of the pandemic in Africa. For one, preexisting health conditions are a significant concern. The large presence of comorbidities may impact the health outcomes of those that become ill with COVID-19. For example, in 2018, an estimated 25.6 million people were living with HIV/AIDS in sub-Saharan Africa. Moreover, endemic malaria, tuberculosis, yellow fever and other communicable diseases make the potential of COVID-19 gaining momentum across the African continent especially dangerous.

There are several factors potentially weighing in the African continent's favor. This includes the relatively young age of the population (with more than half below 20 years old). While of course, youth does not provide immunity against the disease, it may mean that COVID-19 symptoms could be more mild or moderate in this population. There is also comparatively less international travel between cities in the region via air, railway or bus as contrasted with other regions, which may slow down community transmission once it begins in earnest.

Additionally, there is an opportunity to draw on the resilience, creativity and innovation in African societies. For example, Senegal has developed one dollar rapid testing kits, in Chad town criers are helping to disseminate information

about COVID-19 to rural areas and in Kenya textile factories have transitioned to mask-making. Further, several African countries have a recent history with the Ebola epidemic and other disease outbreaks, from which they can draw lessons learned regarding rapidly tracking down, screening and isolating those potentially infected with COVID-19. For example, during the Lassa fever outbreak, Nigeria built up its lab capacity. Also, numerous countries developed their airport infrastructure to monitor the temperatures of arriving passengers to check for any signs of fever during the Ebola crisis. African countries potentially stand to benefit from being in the position to watch what is taking place on other continents with COVID-19, drawing on local knowledge and expertise and using that opportunity and lead time to prepare a proactive response.

Yet, countries cannot simply copy-paste and apply policies in a rigid fashion on the African continent. For one, much of employment takes place in the informal sector in numerous countries. This makes strategies based on working from home inapposite for many. Stay-at-home orders also presume the privilege and ability to maintain social distancing, which may be impossible to achieve where people are living in crowded dwellings, in densely populated urban areas, in informal settlements or in slum areas.

Isolation strategies in conditions where people maybe facing inadequate access to clean water, poor sanitation and little to no electricity come with their own public health risks. Some countries are deploying the "Veronica Bucket," invented by Veronica Bekoe, a Ghanaian public health official during the Ebola epidemic. The bucket and a basin are placed on top of a wooden stand and these mini hand-washing stations are appearing in public areas to account for the inaccessibility of quick and easy sanitation for many. Similar COVID-19 containment strategies must be developed that are flexible and sensitive to local conditions.

Moreover, public health strategies aimed at "flattening the curve," assume some minimum level of healthcare capacity to respond to the initial shock of increased demand for intensive care and other hospital resources during the pandemic. The idea is to draw out the timeline of the pandemic so that everyone that needs access to critical care can get it and to stall until a robust

vaccination or treatment regime is in place. Yet, the capacity constraints of health systems on the continent in many places will not be able to withstand an initial domestic surge in demand. For example, in Burkina Faso there are 11 ventilators for a population of 20.9 million, in Sierra Leone there are 13 ventilators for a population of 7.9 million, in the Central African Republic there are 3 ventilators for a population of 4.8 million and in Somalia there are 15 ICU beds for a population of 15.8 million.

The notoriously weak healthcare systems in some countries has meant that it is common practice for government officials and the well-to-do to go overseas to seek medical care in other African countries like Ghana or South Africa, or in India, Europe or the United States. Border closures and travel bans due to COVID-19 have essentially closed-off this option for the elite. They now must contend with the fragile health systems and informal networks of care that the rest of their populations have depended on.

In 2001, under the auspices of the African Union countries pledged to allocate at least 15 percent of their budget to the health sector each year. Yet, two decades on, health investment in most countries is lagging significantly behind. Inadequate health spending across the continent is in part influenced by the substantial amount of money countries must dedicate to servicing debts.

Briefly, the International Monetary Fund (IMF) and other actors provided loans to encourage the “structural adjustment” of an economy as a condition for extending and refinancing debt. The austerity measures included cutting the budget deficit and improving the balance of payments. Countries accomplished this through budget ceilings, wage caps, and/or reductions in wages in the public sector.

Restrictions on public-sector wages by the IMF and others, meant that countries had limited money to employ and adequately remunerate doctors, nurses, and other health care professionals. As health care employment opportunities lessened, health care quality and a capable health care workforce concomitantly decreased. Furthermore, depressed wages in the public health system contributed to the brain-drain problem in the health sector (where indigenous talent leaves for greener, more prosperous pastures).

The IMF's policies prioritized short-term economic objectives over long-term investments in public health and the result predictably hollowed out the health sector. It is of course impossible to isolate the impact of structural adjustment policies from other variables. Yet, it seems likely that these reform policies were at least a substantial factor in producing weaker health infrastructure. For example, some studies have shown that the IMF's policies have slowed down improvements in, or worsened, the health status of people in countries implementing them. Additionally, an independent evaluation of the IMF's loan programs surveyed 29 countries in sub-Saharan Africa between 1999 and 2005 and found that 37 percent of all annual aid increases were diverted to beefing up currency reserves, with another 37 percent going to repay debts in line with the dictates of structural adjustment—leaving only 27 percent for health and other pressing developmental needs. While correlation does not equal causality, the analysis above indicates that the cumulative effects of the structural adjustment programs likely detrimentally impacted health systems in several countries.

Remarkably, during the midst of the 2014-2015 Ebola crisis, the IMF belatedly recognized the connection between its policies and the outbreak. IMF Director Christine Lagarde observed at a meeting on the epidemic that, "It is good to increase the fiscal deficit when it's a matter of curing the people, of taking the precautions to actually try to contain the disease. The IMF doesn't say that very often." It appears that history is repeating itself with COVID-19. The G-20 countries recently decided to temporarily freeze the debt of 40 African countries in order to free-up funds for countries to be able to more effectively respond to the pandemic.

Some African leaders have even called for the creation of a global fund to prevent the collapse of health systems in Africa, with a facility to provide budgetary support. The African Union has also assembled a continent-wide response to COVID-19. For example, the Africa CDC established the Africa Taskforce for Coronavirus, which is supposed to assist countries with strengthening and building their technical capacities, stockpiling personal protective equipment and quality-assured diagnostics, sharing information and best practices as well as coordinating detection and control at borders amongst others.

Yet, much more than what has been announced thus far is needed. As Chikwe Ihekweazu, Director-General of the Nigeria Centre for Disease Control commented:

> *If we all say that we live in a global village, and health security is everybody's problem, then why are we not developing our response with that notion in place? You can't say that global health security is everybody's problem, yet within the global system access to diagnostics, access to therapeutics, access to vaccines is managed through a pathway that limits the access to parts of the world, because inevitably we put ourselves collectively at risk. I think that our whole thinking about health security has to change. The concept of every country trying to look only within its own borders is completely, mindbogglingly, a waste of everybody's time.*

Indeed, in *Responsibility for Epidemics*, I argue that a common but differentiated framework of responsibility is necessary to: (1) recognize special situations of need in one or more countries with epidemic diseases; (2) assign greater responsibility to those who have contributed more to an epidemic; and (3) assign greater responsibility to those who have more resources or capacity to deal with an epidemic. The hyper-visibility and saliency of COVID-19 may mobilize greater global action towards implementing some aspects of this framework.

The normative justification for differentiation based on need is straightforward—morally, we have a responsibility to help those in need. Differentiating based on relative health needs makes intuitive sense because while public health risks are distributed across all nations, as the COVID-19 pandemic has demonstrated, some countries are more needful of assistance than others and are especially vulnerable to highly infectious diseases. Yet, meeting the global need required to address highly infectious diseases requires more than the resources of any one state, as such obligations to cooperate must be shared and differentiated not only based on need, but also based on capacity.

The normative justification for differentiation of responsibilities based on capacity is intuitive—if we want to effectively combat highly infectious

diseases, then we should allocate responsibility to those that are best placed to do so. Relative capacity, as opposed to absolute capacity, to act will be crucial in determining responsibility. Indeed, it may be more socially desirable and legitimate for actors that have high capabilities (but are not the most capable globally), to act to remedy the harm caused by an epidemic or pandemic disease. Otherwise, requiring action from only the *most* capable actors could reify geopolitical hierarchies in ways that allow for powerful actors to exercise oversight over programs aimed at combatting highly infectious diseases. This could serve to immunize the actions of more well-resourced actors, which would sustain a problematic role between countries in the Global South and those in the Global North. I discuss this component of the framework in more detail in *Capacity, Cooperation and COVID-19* in a forthcoming piece in ASIL Insights.

While all aspects of the framework are important, differentiating based on culpability requires more exposition. The relevant primary obligations of states for pandemic diseases are located under several fields. For instance, global public health law seeks to "prevent, protect against, control and provide a public health response to the international spread of disease." The International Health Regulations create a system of state surveillance and notification for certain infectious diseases. Another important framework is human rights law, which includes protections against the arbitrary deprivation of life and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Where a state violates these international law obligations, it is to provide redress for the injury caused by the internationally wrong act as under the law of responsibility, every internationally wrongful act of a state comes with international responsibility.

In COVID-19 and Allocating Responsibility for Pandemics, I discuss the act, mental, and causation elements for allocating international responsibility for highly infectious diseases in more detail. Briefly, the initial causation inquiry should be revised from the traditional but-for test, to focus on whether a given set of actions and omissions were at least substantial factors in producing or contributing to serious adverse consequences witnessed during an epidemic or pandemic. The second step in establishing causation generally requires that the resulting harm be not so remote that it would be illegitimate to hold a specific

actor accountable. Yet, a wide-ranging culpability analysis should necessarily lengthen the causal gaze temporally to fully account for the status quo vulnerabilities of health systems to highly infectious diseases. Such an approach would examine the direct, indirect, and multiple causal factors, as well as historical responsibility as bases for culpability for pandemic and epidemic diseases.

Differentiating based on culpability would not leave states solely responsible for addressing adverse health outcomes that exist, in part because of structural conditions in the international system. Unsurprisingly, actors in the Global South will be the most vocal proponents of historical responsibility as a ground of differentiating culpability, while actors in the Global North will likely tend to be the most hostile or ambivalent to it. There are numerous studies that have demonstrated the long-term detrimental consequences of the legacies of slavery and colonialism on the current economic performance and position of countries in the Global South. For example, the 2014-2015 Ebola epidemic in West Africa was the result of historical vulnerability from slavery, colonialism, neocolonialism, bad governance informed in part by dictators propped up during proxy wars, neoliberal reform policies like structural adjustment, a recent history of conflicts and narrow post-conflict reconstruction, which cumulatively hollowed out the health sector. For actors in the Global South, the way things are—the status quo—remains the key issue. A common argument against such claims is that the actors of today should not be held responsible for the sins of their predecessors. However, history must be owned. As far as historical responsibility can be traced to a common lineage, the bearers of that lineage must face the “future in the shadow of the collective past.”

An alternative normative basis for differentiation based on historical responsibility would be to deter actors from engaging in harmful action in the future. Normative support can be located in the principle that actors should not benefit from their wrongdoing and should compensate those that have been harmed because of their actions. It may be easy for actors in the Global North to assert that bygones should be bygones when they continue to benefit from those bygones, while the detrimental consequences are experienced primarily elsewhere in the Global South. While highly infectious diseases affect both industrialized and developing states, the detrimental consequences of these

diseases will be more severe in the Global South. If the objective is to contribute to global justice, then we must create proper incentives and disincentives for actors such that they do not benefit from unjust enrichment. In some sense, historical responsibility as a basis for differentiation requires that actors internalize the detrimental effects that they impose on others. A deterrence rationale posits that it is only when actors take responsibility for their actions that future harm is likely to be avoided. Indeed, detrimental action without consequences does not usually get the incentives right. The COVID-19 pandemic and the responses to halt its spread have already created a world which few had previously envisioned. Perhaps it will be more possible today than it was yesterday to harness this potential to create a more just world order.

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