THE POLITICS OF MANAGING EPIDEMICS AS GLOBAL SECURITY THREATS: THE CASE OF COVID-19 AND GHANA

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DECLARATION

I hereby declare that this dissertation is the result of original research conducted by me under the supervision of Dr. Ken Ahorsu. All sources referred to in the study have been acknowledged and the part has been submitted anywhere else for any other purpose.

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DATE…… **DATE……..……**

DEDICATION

This work is dedicated to God Almighty and my beloved family. A special feeling of gratitude to my loving and ever-supportive parent, Mr. Christian Cizaro Klu and Mrs. Elizabeth Bentsir Benyin. You have been of constant source of support during challenging times. And to Mr. Rexford Johnson whose words of encouragement and push has taught me to work hard for the things that I aspire to achieve.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACDCP	Africa Centres for Disease Control and Prevention
AfDB	African Development Bank
AG	Attorney General
ALAC	Legal Advice Centre
AMA	Accra Metropolitan Assembly
ARO	Alert and Response Operations
AU	African Union
B.E.C.E	Basic Education Certificate Examination
BVM	Biometric Verification Machine
CDA	Community Development Alliance
CDACRAR Report	Community Development Alliance's Corruption Risk Assessment
CDC	Centre for Disease Control and Prevention
CHRAJ	Commission for Human Rights and Administrative Justice
COVID	Coronavirus Infectious Disease
CSIR	Council for Scientific and Industrial Research
CSO	Civil Society Organizations
CTAP	Covid-19 Transparency Accountability Project
EC	Electoral Commission
ECOWAS	Economic Community for West African States
EECSI	Establishment of Emergency Communications System Instrument

EGP	Economic Governance Platform
E.I	Executive Instrument EIS - Event Information Site
EMS	Event Management System
EOC	Emergency Operations Centre
EOCO	Economic and Organized Crimes Office
EPRP	Emergency Preparedness and Response Plan
EVD	Ebola Virus Disease
FDA	Food and Drugs Authority
GAFCSC	Ghana Armed Forces Command and Staff College
GES	Ghana Education Service
GIDC	Ghana Infectious Disease Centre
GIMPA	Ghana Institute Management and Public Administration
GHS	Ghana Health Service
GHSI	Global Health Security Initiative
GOARN	Global Outbreak Alert and Response Network
GOG	Government of Ghana
GSA	Ghana Standard Authority
HIV/AIDS	Human Immune Virus/ Acquired Immune Deficiency Syndrome
IFRC	International Federation of Red Cross and Red Crescent Society
IHR	International Health Regulation
IMF	International Monetary Fund
ISR	International Sanitary Regulations

KATH	Komfo - Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
KCCR	Kumasi Centre for Collaborative Research in Tropical Medicine
KIA	Kotoka International Airport
KMA	Kumasi Metropolitan Assembly
LECIAD	Legon Centre for International Affairs and Diplomacy
MAG	Medical Association of Ghana
MMDA's	Metropolitan. Municipal And District Assemblies
MOC	Ministry of Communication
MOGCSP	Ministry of Gender and Social Protection
MOE	Ministry of Education
MOH	Ministry of Health
NADMO	National Disaster Management Organization
NIA	National Identification Authority
NDC	National Democratic Congress
NICC	National Information Contact Centre
NPHRL	National Public Health and Reference Laboratory
NPP	New Patriotic Party
NGO	Non-Governmental Organization
NFP	National Focal Person
NMIMR	Noguchi Memorial Institute of Medical Research

NPRPPCE	National Prepared and Response Plan for Prevention and Control of Ebola
NTCC	National Technical Coordinating Committee
PCR	Polymerase Chain Reaction
PHEIC	Public Health Emergency of International Concern
PHEMCS	Public Health Emergency Management Committees
PHENC	Public Health of National Concern
PPA	Public Procurement Authority
PPE	Personal Protective Equipment
PROJECT C.U.R.E	Project (Commission on Urgent Relief and Equipment)
RRT	Rapid Response Team
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SCAM	Strengthening Covid-19 Accountability Mechanism
SME	Small and Medium Enterprises
SP	Special Prosecutor
TIA	Transparency International Advocacy
UHAS	The University of Health and Allied Science
UN	United Nations
UNCED	United Nations Conference on Environment and Development
UNESCO	United Nations Educational Scientific and Cultural Organization
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNSIC	United Nations System Influenza Coordination

VSD	Veterinary Services Department
WASSCE	West African Secondary School Certificate Examination
WHA	World Health Assembly
WHO	World Health Organization
WHO-AMRO	Regional Office for African Regional
WHO-EMRO	Regional Office for Eastern Mediterranean
WHO-EURO	Regional Office for Europe
WHO-SEARO	Regional Office for Southeast Asia
WHO-WPRO	Regional Office for Western Pacific

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ABSTRACT

The study analysed the politics of managing epidemic threats with Ghana as the case in point. The securitization theory served as the framework. It was a qualitative study and data was sourced from both secondary and interview sources. It found that Ghana's response to the Corona Virus Infectious Disease (COVID-19) threat was to protect its citizens unfulfilled its responsibilities under the World Health Organization (WHO) and Section 169 of the Public Health Act, 2012 (Act 851) in harmony with WHO's IHR 2005. The 1994 Emergency Powers Act 1994 (Act 472) rolled back civil liberties and imposed autocratic policies. Ghana's role in limiting the 2013 Ebola outbreak in West Africa equipped it with vital skills in pandemic management. Laboratories within and outside the GHS were ascribed to provide testing for COVID-19 raising the testing laboratories from 2 to 16 by April 2020 to reduce facility shortfalls; and the private sector, Non-Governmental Organizations (NGOs), and the global community aided. The regime of COVID-19 was adversely affected by muddles, delusion, and myths that increased vaccine apathy and sapped pandemic rules zeal. The 2020 Elections and political expediency adversely impacted effective COVID-19 control. The huge financial mobilization contracts and supplies engendered by the pandemic promoted corruption. Contracts were awarded without complying with contract and procurement laws, costs of contracts were bloated, contracts were awarded without tenders mostly to unregistered companies, huge sums of funds were not accounted for, unused funds were not returned to government covers, beneficiaries of contracts and source of some fund were not stated, and healthcare and allied workers were not paid wages often. The sleaze resulted in a decrease in citizens' trust, approval, and interest in pandemic activism. The study concluded that socio-cultural and political culture ills such as superstition and corruption dysfunctional impacted the effective and efficient management of pandemics. It recommended high hygiene etiquette and good housing outlays, pro-health government expenditure, counter-misperception and superstitious media, empowerment of Civil Society Organizations (CSOs) with corruption oversight powers, and greater international donors and accountability.

CHAPTER ONE

1.0 INTRODUCTION

Contemporary epidemic (and pandemic) outbreaks, the pervasive threat and anxiety they pose, their exigencies, and the conundrum of containing them have dramatic impacts that intensely affect and shape every aspect of how people, communities, and states live, relate, and govern themselves. President Barack Obama commenting on the Ebola virus that rocked West Africa in December 2013, described contagions as formidable foes that "underscore – vividly and tragically – what was already known: that in an interconnected world, outbreaks anywhere, even in the most remote villages and the remote corners of the world, have the potential to impact everybody, every nation" (Obama, 2014). He warned that the threat is pervasive: "nobody is that isolated anymore;" "Oceans don't protect you. Walls don't protect you." President Obama advised the world to change its assumptions and attitudes towards epidemics as purely public health issues and begin rationalizing epidemic threats as security threats that additionally pose humanitarian and economic threats. And he exhorted the world to accord the fight against epidemics and the challenges they pose the same level of dedication and concentration as they do when tackling the more traditional security threats (Obama, 2014).

Obama's exhortation of the necessity for a more critical examination of epidemics as a security priority mirrors the acute threats recent epidemic outbreaks such as the Severe Acute Respiratory Syndrome (SARS) (2013), Ebola (2014), Zika (2015), and COVID-19 have posed. Epidemics over the years serve as one of the largest menaces to humankind claiming lives at a faster rate than most past wars (Lemay, 2006). Aided by unprecedented advances in communication and transportation technology in today's ever-globalizing world, epidemics can spread vectors across the globe in record times (Ahorsu, 2017). The conceptualization of security and its practice since 1992 has changed markedly. Security and its exigencies are no more limited to the restricted confines of military threats. Climate change and its attendant ecological threats, migration, poverty, energy, and epidemicsare now often conceptualized as some of the non-traditional security threats (Collins 2006, Booth 2007). Epidemics and pandemics, biological weapons, and bioterrorist attacks have particularly gained plausibility as transnational security threats (see McInnes and Lee 2006).

In 2021, the outbreak of COVID-19 in China and its implacable spread across the world is a tectonic plague that has spawned fear, threat, anxiety, casualties, and mobilizations to apocalyptic dimensions. Both developed and developing countries around the world have

suffered huge deaths within a very short time unparalleled by battlefield losses in the past. Efforts to contain epidemics necessitate mobilizations that mirrored but surpass wartime mobilizations have reshaped the contours of international relations, diplomacy, security, medicine, (international) public health, microbial, and migration studies, and reiterated the framing of health issues as (transnational) security threats with world-shattering pressures that threaten human survival. Its threats, fatality rates, anxiety, management, global mobilization the attendant divisive politics appear to have confirmed the uneasy relationship between politics and public health. It has bridged the gulf between national security and microbial threats, a field measured by scientific rationalities and a predilection towards cosmopolitan norms. COVID-19 as a security threat has proved to be politically charged and sometimes divisive. It has resulted in diplomatic scuffles between the United States (US) and China, and the temporary of the US from WHO. The management of the COVID-19 crisis apart from posing an existential threat to communities and societies has also posed a legitimate threat to governments. One of the advantages of the securitization f health, health-security nexus, is that it is a coeffective way to mobile resources and create awareness about the control of the disease.

The pervasive perils the COVID-19 epidemic pose has imposed revolutionary pressures on governments and international leaders to enact policies and mobilize resources in record capacity and time to contain the deadly epidemics. It meant rolling back civil liberties especially freedom of movement and gathering in groups. Thus, the management of epidemics and pandemics no longer entails only healthcare systemic capacities, but also political capacities essential to mobilization of healthcare resources and emergency political measures to ensure public compliance and social order with somewhat autocratic measures as management responses. Kavanagh and Singh note, in their work on COVID-19; "Strong infrastructure and 'stability' are not sufficient. The state, in all its capacity, must be mobilized through political processes" (Kavanagh and Singh 2020: 5). Thus, effective, and efficient epidemic (and pandemic) readiness and responses are not only technical matters but also political and normative ones since compliance with measures and its social stability task governments' ability to sustain a delicate balance between forcible political capacities and legitimation capacities. Coercive measures, every so often, deployed in repressive or semi-authoritarian contexts have shown effectiveness in sustaining the COVID-19 outbreak. (Woo, 2021).

Political capacity in managing emergencies created by epidemics is associated with several different facets of policymaking and policy processes concerning governments' abilities to push through and attain policy goals through more invasive ways that seek to handle or balance manifold interests, stakeholders, and even resistance. It also relates to the government's capacity to maintain trust, credibility, and legitimacy. Thus, safeguarding larger public acquiescence with and compliance with its policies and regulations through trust and persuasion (Woo, 2021). Political capacity, according to Kugler (2018, 1), refers to the "ability of political systems to carry out the tasks chosen by the nation's government in the face of domestic and international groups with competing priorities." Institutional foundations, on the other hand aids governments in successfully devising and deploying policies, decrees and imposing laws (Fukuyama, 2013). Apart from state power, extra institutions and structures of the state that foster collective capacity and contribute to 'social capacity' such as the bureaucracy and courts also participate in certifying larger political capacity (Fukuyama 2011, 2014; Ostrom, 2005). Political capacity or legitimacy capacity in the management of epidemics also comprises of the socio-political credibility and trust of authorities and leaders, policy efficiency, information transparency, political communications skills, leadership and flexibility skills, and wider legitimation processes. These are essential for public institutions and policymakers to guarantee public backing for policies and promote better compliance with rules and regulations, particularly within the social realm, political environment, economic sphere, and security realm (Woo, Ramesh, and Howlett 2015; Gesser-Edelsburg and Hijazi, 2020).

The foundation of this research is that the securitisation and containment of epidemics within the community of nation-states cannot be considered as a monolithic process. The political culture and national resources, and domestic, social, and political context, within nation-states drives their responses to epidemics as much as, if not more than the global discourse of health security. In other words, there is, plausibly, corresponding gulf between the developed world and the developing world's political capacity in securitising, managing, and containing epidemics as transnational security threats. I call the incorporation of the social and political context within which securitisation processes occur, and the political capacities that are deployed to contain epidemics, the politics of managing epidemics. This, I believe, adds a nuanced hermeneutic depth and recognition of the situated audience and the political elites, especially, in terms of the domestic political structures that has implications such as successes and challenges for the global public health securitisation process. The study uses the *politics*

of Ghana's management of the COVID-19 threats as a case study. It focuses on the response of the government towards the pandemic and serves as evidence on how developing and sub-Saharan African countries manage the emerging epidemic threats. It accents the challenges faced by developing countries with delicate public health system, deepened by the contradictions and pressures characteristic of the country's political, economic, and socio-cultural realities. It also addresses issues of discrimination, corruption, and maladministration.

On March 11, 2020, COVID-19 as a Public Health Emergency of International Concern (PHEIC) was declared by WHO. On the 13 March 2020, Ghana confirmed two cases of COVID-19. The two confirmed cases were travellers from Norway and Turkey. According to Marian Nkansah (2020), the sensitisation and public etiquette on epidemics and pandemics that Ghanaians acquired during the 2014-16 Ebola outbreak in West Africa, although Ghana did not register a case, prepared Ghanaians against COVID-19. The "National Preparedness and Response Plan for Prevention and Control of Ebola (NPRPPCE)" helped build and strengthen institution to help address possible epidemic breaks. At the time, Ghana was equipping itself towards the 2020 Presidential and Parliamentary Elections. Political parties, the Ghanaian public, academic, health workers, businesses, Churches, Mosques, traditional rules, schools, and security agencies were sensitized and mobilised against the threat and spread of the epidemic in various forms of interventions. The use of face masks, gloves, alcohol-based hand sanitizer, social distancing, abstinence from handshakes and physical contacts, hand washing with detergents, checking of temperatures and fumigation exercise in most public service places and at the entry ports to was undertaken to prevent the spread of the epidemic. Eight hundred and eight (808) prisoners were freed to decongest the prisons. Public sensitization and creation of awareness on COVID-19 were mainly through reportage from media outlets. Since March 12, 2020, the President of Ghana, government officials, and health directors addressed the Ghanaian public regularly on the state of infections, deaths, and other exigencies of the pandemic.

The Ghana Health Service (GHS) and the Medical Association of Ghana (MAG) under the Ministry of Health (MOH) and the National COVID Team were the front fighters against the COVID-19 spread through education, prevention, testing, tracking and quarantine, treatment. The Noguchi Memorial Institute of Medical Research (NMIMR) in Accra, the Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR) in Kumasi, and later the University of Health and Allied Sciences (UHAS) in Ho, were mainly responsible for testing blood samples. The Ghana

Standards Authority (GSA) and the Food and Drugs Authority (FDA) were the institutions in

charge of certifying drugs and accessories used in the management of COVID-19 in Ghana.

Ghanaians were advised to avoid travelling abroad as much as possible. All approved entry points including land and sea borders and airports were fumigated and all incoming travelers screened. Universities, schools, churches, mosques were closed temporarily. On March 15 2020, all public gatherings were banned, and the Greater Accra Metropolitan Assembly (AMA) and the Greater Kumasi Metropolitan Assembly (KMA), the two main epicenters of the COVID-19 infection were locked down on March 27, 2020. Despite the ban on public gatherings, the National Identification Authority (NIA) continued its mass registration of the Ghana card in the Eastern region. A court endorsed the continued registration exercise even as the Ghana Medical Association threatened a strike action should the NIA not cease the registration. The NIA eventually called off the registration exercise during the pandemic. On March 21, 2020, Ghana's land, sea, and air borders were closed to human traffic, and all travelers entering Ghana were subjected to a 14-day compulsory quarantine and testing protocol. On March 23, 2020, all beaches in the country were closed down.

To garner funds for the additional financial burden COVID-19 imposed on the country, Ghana COVID-19 National Trust Fund was instituted. Well-meaning individuals, religious groups, the private sector, political parties, and Ghana's development partners contributed their quota to the Fund. Several organisations and individuals made donations openly to hospitals, scientific research centre, prisoners, the destitute, and government, among others. A Board of Trustees was inaugurated on March 29, 2020, to manage affairs of the Fund. Government officials such as the President and his Vice, and Parliamentarians donated their salaries and 50% of their 3 months salaries, respectively, to the Fund. During the total lockdown, the Ministry of Gender, Children and Social Protection (MoGCSP), Metropolitan, Municipal and District Assemblies (MMDA's) and National Disaster Management Organisation (NADMO), and religious organisations at different times distributed food and other supplies to the vulnerable. Free water was supplied, and Ghanaians benefited from a waiver up to 50% on electricity consumption from April-June 2020. Front line health workers also benefitted a 50% increase in their basic salary and Life Insurance Cover. Otumfuo Osei Tutu also set up the One Million Ghana-Cedi fund on April 1, 2020. Bank lending rates and other charges were lowered to ease COVID-19 pressures. And 600 million cedis soft loan was disbursed to industries that suffered negative COVID-19 impacts.

The President of Ghana has passed four Executive Instruments (E.I) to provide legal backing to the COVID-19 containment directives made so far. They are; E.I.63 on 'Establishment of Emergency Communications System Instrument (EECSI) 2020, gazetted on 23rd March, 2020; E.I. 64 on 'Imposition of Restrictions (Coronavirus Disease (COVID-19) Pandemic) Instrument, 2020, gazetted on 23rd March, 2020; E.I.65 on 'Imposition of Restrictions (Coronavirus Disease (COVID-19) Pandemic) (No.2) Instrument 2020, gazetted on 30th March, 2020 and E.I. 66 on 'Imposition of Restrictions (Coronavirus Disease (COVID- 19) Pandemic) (No.3) Instrument, 2020, gazetted on 3rd April, 2020.

From March 2020 to July 2021, 1341937 were tested and 98 114 tested positive Ghana has since by 11 July 2021 806 deaths officially recorded. April 19, 2020, been lifting the sanctions gradually, while the safety measures are still in place. The airports are open except the land borders. At the time of this study, the recent announcement by President Nana Akufo-Addo was a relief for migrant workers, stranded Ghanaians abroad, law makers, Ghanaians in the diaspora with dual nationalities and students.

1.1 PROBLEM STATEMENT

As stated above, the pervasive perils of epidemic have imposed ground-breaking pressures on governments and international leaders to enact policies and mobilise resources in record capacity and time to contain deadly epidemics. It meant rolling back civil liberties, especially freedom of movement and gathering in groups. The management of pandemics no longer entail only healthcare deliveries, but also political capacities required to mobilise healthcare resources, and emergency political measures to ensure social order and public consent to dramatic epidemic responses. Kavanagh and Singh (2020, 5) have noted, "Strong infrastructure and 'stability' are clearly not sufficient. The state, in all its capacity, must be mobilized through political processes." Thus, effective, and efficient epidemic readiness and responses no longer involve only health technicalities. Such responses are also political and normative in essence since public compliance with rather dramatic measures and social stability depend on governments' ability to maintain a delicate balance between forcible political capacities and legitimation capacities. Coercive measures deployed in repressive or semi-authoritarian contexts have proved highly effective in containing the epidemic spread as states handle manifold interests, stakeholders, and even resistance. States' capacity to sustain trust and legitimacy ensures more public compliance with government policies through trust and

persuasion (Woo, 2021). Success also depends on socio-political credibility and trust of leaders, policy efficacy, information lucidity, communications skills, leaders' flexibility, and efficient institutions. Authoritarian rules may also have adverse implication for social, political, and economic well-being.

Since states are one of the most important actors within the politics of securitisation and international public health chain, the state's efficacy remains critical to the management of epidemics in Ghana (as referent case for developing countries in West Africa). The study analyses Ghana's deployment of resources and organisational capacity or political capacity given its socio-political dynamics, political culture, and ethics. Ghana is a post-colonial state in democratic transition with multiple threats competing as referent objects of security within the state apparatus. It is still in the process of state-building, and the internal power struggles between social groups and elites, and resource inadequacies are common. It is structurally weak, burdened by high foreign debt, superstitious, and under-investment in infrastructure especially in the public health system. Its socio-cultural practises are often marked by unsafe handling of sickness, the sick and the dead. It has a vibrant but partisan media. And it suffers from political polarisation, and corruption. It is under these structural conditions and exigencies that the COVID-19 epidemic is securitised and managed by the state and people of Ghanaian.

Since March 2020, in the run-up to the 2020 Presidential and Parliamentary Elections, Ghana has instituted several legislations regulating public health and hygiene practices such as social distancing, the use of nose masks, and handwashing in public, commercial, and official premises. The borders were closed and major cities as Accra-Tema and Kumasi were locked down for three weeks. Schools were closed, and religious and other social gatherings were banned. Testing, quarantine, and contact tracing of exposed persons and positive cases were carried out amidst stern warnings, and threats of fine and incarceration. Government, health officials, and mass media regularly reported the rate of infection, recoveries, and deaths. Local production of public health goods such as masks and sanitizers were boosted. Financial, medical, and infrastructural capacities of institutions handling the COVID-19 agenda were boosted by the Government's COVID Fund, United Nations (UN), World Health Organization (WHO), World Bank/ International Monetary Fund (IMF), the African Union (AU), African Development Bank (AfDB), the Private Sector, Faith-Based Organisation, Individuals, and global NGO's, among others. From September 1, 2020, Ghana begun to ease its COVID-19 restrictions, its international airport was opened, but land and sea borders remained closed.

There were scores of reports of police misconduct, military abuse, and political gerrymandering that bordered on impunity. National identity card registration that qualified citizens to register as voters went on in the Eastern Region amidst the ban on social gathering with accounts reporting chaos and overcrowding. Despite official briefings, it was challenging to determine how accurate COVID-19 related data was collected, controlled, and interpreted. For example, did COVID-19 deaths and recoveries that were reported reflect the reality since the question of 'other deaths' were not clarified in the MOH's reports? The COVID-19 regime did not diagnose and report other deaths in Ghana. Floppy changes that characterised the COVID-19's test and trace regimes, reporting, and sorting of "recoveries" were reported have implications for dependable statistics (Peace FM 2020).

The New Patriotic Party (NPP) and the National Democratic Congress (NDC) the two largest political parties in Ghana, and government officials spun uneven and even contradictory and contentious narratives about the virus to gain political support (Joy FM, 2020). While the government claimed the continued closure of the land borders was COVID-19-related, others alluded the exigencies of the 2020 Elections. Myjoyonline alleged that the government's response was tainted with corruption (2020), and highly politicized (Salia 2020; Vomafa-Akpalu 2020). The complete lockdown was brief and limited, but the strict regulatory measures and the management of the COVID-19 funds put Ghana's securitisation and management of COVID-19 in a poser.

Another intrigue about Ghana's securitisation of COVID-19 and its ramifications is criticism of the securitisation theory and processes as being Eurocentric. Meaning that the Copenhagen School takes states as given and undifferentiated. This raises several thought-provoking questions for non-Western and non-traditional democratic states such as Ghana. Does the social and political context influence and shape the securitisation processes of states? In other words, how does the analyses of domestic referent, political legitimacy, and audience interaction in non-Western, and transitional democratic developing states such as Ghana impact on the securitisation process and outcomes of epidemics? The study focuses on how Ghana, a fragile state legitimacy with competing referents and political culture, utilises language that is heavily conditional to the audience to which they are alluring in the management of COVID-19.

1.3 RESEARCH QUESTIONS

- What is securitisation theory and are the processes of securitising epidemics and pandemics?
- How did the Ghanaian government and the public securitised the COVID-19 epidemic?
- When how and what (institutions, rules, values, and resources) did the Ghanaian government used in managing and containing the COVID-19 epidemic?
- How did the social, economic, and political structures impact on the securitisation of COVID-19 in Ghana?
- How successfully was the COVID-19 epidemic managed and contained and what challenges did the management of COVID-19 encountered and engendered?

1.4 OBJECTIVES

The core objective of the study is to analyse the politics of managing epidemics as global security threats with Ghana as the case in point. It specially seeks to,

- Expatiate securitisation theory and are the processes of securitising epidemics and pandemics
- Analyse how the Ghanaian government and the public securitised the COVID-19 epidemic;
- Examine when, how, and what (institutions, rules, values, and resources) did the Ghanaian government used in managing and containing the COVID-19 epidemic;
- Analyse how the social, economic and political structures impacted on the securitisation of COVID-19 in Ghana.
- Study how successfully the COVID-19 epidemic was managed and contained and what challenges did the management of COVID-19 encountered and engendered; and,

1.5 THESIS ARGUMENT

Ghana has done relatively well in managing the COVID-19 threat; however, its political culture has undermined its efficiency.

1.6 SCOPE OF THE STUDY

The research addresses the securitisation of epidemics as international security threats. The emphasis is on the politics of securitising and managing epidemics in weak post-colonial states in West Africa. It uses Ghana as a case study. The analysis the securitisation, management, and containment of the epidemic in Ghana from March 2020 to September 2021. It specifically examines the roles and effects of situated actors, institutions, political culture, values, resources on the securitisation, and containment of the epidemic.

1.7 RATIONALE OF THE STUDY

The (re)emergence of epidemics and pandemics and the existential threats they posed to today's ever-globalising world is one of the most revolutionary pressures undermining the comfort and stability of the world. Human Immune Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS), SARS, Ebola, Zika, and COVID-19 are some of the epidemics that have had the most overwhelming impact on the world and its people. COVID-19 infection is globally 439,421,085 and over 5,987,035 deaths as of March 2, 2022 (Worldometer, 2022). The developed world suffered most from the scourge. The lessons are that epidemics threaten both rich and poor nations, and both the rich and poor without differentiation. The sheer volume of deaths within a short time surpasses most past battlefield deaths. The social discomfort, emotional scars, and social disruptions caused by the epidemic can never be clearly ascertained.

The economic hardships, misery and the unpredictability that the epidemic has imposed on the world is unfathomable. The Epidemic has equally caused a lot of conflicts globally and within societies. And the search for solutions has witnessed one of the widest and largest mobilisations. For developing countries, the emergence and threats of epidemics are perhaps, the threats of the future. It is hoped that the findings of this study will demonstrate what developing countries did well, can do better and the challenges they face in both securitising, managing, and containing epidemics.

1.8 THEORETICAL FRAMEWORK

The study employs securitisation theory as its framework. The term securitisation was first employed by Ole Wæver in 1993 (Lipschutz, 1995; Wæver, 1996; Buzan, 1998). Securitization theory in international relations is associated with the Copenhagen School of thought. It is an amalgam of constructivism and classical political realism in terms of methodology (Williams, 2003). Securitisation theory is a creative attempt to answer the question: What is security? It answers the questions: Who are the genuine authors of security policy, which beneficiaries should have precedence, or what are the most satisfactory strategies of its implication? It answers the 'who, what, where and how' of security, (Ciuta, 2009). It holds that national security policy is not given, but prudently chosen by elites through their decisions. Politicians and decision-makers usually delineate a referent object and label and constitute them as existential threats that are 'dangerous,' or 'threatening,' and that needs emergency solution (Eroukhmanoff, 2018).

A speech act concerning an issue is the beginning of a securitization process, by an authoritative national leader, institution, or party. The speech act attempts to move the issue from ordinary discourse or politics into one of an extreme security concern that legitimates extraordinary measures to contain it (Anatol Lieven, 2020). Unlike the traditional styles of security that focus on the material outlooks of a threat such as military abilities, distribution of power, and division, securitization scrutinises how issues are converted by an agent into an existential threat to warrant the use of extraordinary measures.

For the securitization act to be popular and accepted, it must be approved by a situated audience. "Securitization is a rule-governed practice, the success of which does not necessarily depend on the existence of a real threat, but on the discursive ability to effectively endow a development with such a specific complexion" (Balzacq, 2005). The audience may be technocrats, administrators, public officials, and policymakers, among others, who play varying roles in accepting a securitization of an issue (Roe, 2008).

The securitising actor or agent often imbued with social or institutional power makes the securitizing move/statement moving the referent object 'beyond politics.' For example, labelling immigration, and epidemics as threats to national security, moves immigration and epidemics from economic and public health concerns to a priority of political concern that need urgent and extraordinary action such as fortifying borders and imposition of semi-authoritarian

public health regime, respectively. 'Security' is, thus, not necessarily universal, or positive, but contextual and subjective, even negative at times (Fierke 2015).

Securitisation theorists have delineated five spheres: economic, societal, military, political and environmental in which securitisation takes or may take place. Identity is the referent object in the societal sector. Ecology and threatened species are the referent objects in the ecological segment. The state remains the referent object in the security sphere. The essence of 'sectorialising' security means that security relates to diverse features of each referent object that highlight the circumstantial nature of security threats. For instance, terrorist attacks are a larger cause of anxiety for some publics than for others; yet it is securitised by the West as a 'global' threat.

An essential element of securitisation theory is vetting the discourse or linguistic structure of decision-makers when they label an issue and try persuading an audience to elevate the issue as a critical security issue. Through a speech act such as "saying the words, something is done, like betting, giving a promise, naming a ship" issues are securitised (Buzan, Wæver and de Wilde 1998, 26). A speech act is imperative since in discourse analysis words do not just depict reality but constitute reality and take on 'lives' of their own that then triggers specific responses. To persuade an audience to accept issues as security threats, the securitising agent draws attention to and every so often amplify the exigence and intensity of the threat to convey a critical moment, often to frame such in military terms.

An issue, only, becomes securitised when an audience communally agrees on issue as an existential threat and backs the need for extraordinary actions. It fails if the audience rubbishes the securitising agent's speech act. The leitmotif running through securitisation theory is to remove from the sole preserve of politicians and place it in the hands of the audience who has to sanction the speech act as a security threat.

The securitisation process has been criticised by some scholars as being overly simple. The critics argue that securitisation should be understood as a more arduous and protracted process of continuing social constructions and negotiations among various audiences and speakers. And that security issues range from non-politicised or publicly debated to a politicised or publicly debated to those securitised as an existential threat that legitimised action under discourses of urgency that merit extraordinary measures. Daniel Deudney (1990) has critiqued securitisation as being too likely to cause the emotional influence of dysfunctional nationalism.

Even securitisation advocates like Anatol Lieven (2020), concur that securitising an issue can unleash overreaction by state agents. For instance, the wars on terror have witnessed excesses.

Many scholars have used the securitisation theory to study epidemics and pandemics as security threats (Vouri, 2008; Yuk-Ping, 2010; Roe, 2012; Kamradt-Cot, 2012; Hanriedar. 2014; Balzack *et al*, 2016; Stathopulos, 2019; Bengstsson & Rhinard, 2019; Eves & Thedham, 2020). Many pro-securitisation scholars have criticised the theory the centrality of audiences in the securitisation process from a nuanced perspective. In securitisation epidemics, McInnes and Enemark argue that 'fear' in citizens helps identify which diseases should be securitised. But the critics ask, in whom do these diseases inspire fear? How do audiences come to dread these diseases and regard them as security threats? They reason that audiences such as individuals or collectivities are different, given the context, in the way they value threats and the way they become fearful. They, therefore, contend securitisation theory is overly Eurocentric and traditional democracies biased (McSweeney 1996, Hansen 2000, Williams 2003, Stritzel 2007, McDonald 2008, Ciută 2009). And that the 'facilitating conditions' which inform the reaction of a developed world audience to securitising attempts, may not necessarily be the same in the developing world.

As such, securitisation processes may proceed in dissimilar, and possibly arbitrary and more uneven ways than in traditional democratic societies. They also criticise the theory's over-emphasis on linguistic speech acts as the key evidence to locating cases of securitisation, overlooking other possibly feasible and vital non-verbal means through which the audience reacts to the securitising goals of the state. They call for adequate incorporation of socio-cultural and political contexts in which securitisation processes occur. And that critical issues of social structuring and linguistic legitimacy which informs the securitisation process are essential and should not be understood purely as an act of persuasion (Balzacq, 2005; Vuori, 2008).

The critics argue that in developing countries' context, the application of a purely analysis of linguistic does not account for the detailed negotiated relationships between the 'audience' and political elites. Since the impact of weak domestic political structures with fragile legitimacy employs the use of competing referents and language that will be worryingly contingent upon an audience that are largely not abreast with the exigencies of epidemics to which they appeal to operationalise international public health discourses (Wilkinson, 2007).

The post-colonial or transitional democratic state is in no way a unitary actor, many influences outside the remit of the state persist that influence state policies and its ability to execute security policy. Besides, many fonts of 'threats' contend for consideration as referent objects of security within the state machinery to the extent that outlining a referent object of security becomes echoes wider contentions over state-building and other national power tussles between rival social groups and elites (Upadhyaya, 2006).

The criticisms of securitisation theory and the call to contextualise its operationalisation resonates with the context of Ghana, where political legitimacy and structures are fragile, variances in geographical, socio-economic, and political situations visibly affect state-civil society relations, especially, communication between elites and citizens at the grassroots level, and the capacity of citizens to criticise views on state security speech acts. Nevertheless, the theory of securitisation is relevant to the politics of managing epidemic as security threats. The demand of the critics that the theory should be conceptualise suits the study. In the end, the findings will make contribution to the knowledge since the theory when applied to the Ghanaian context will reveal what is common to securitisation globally and what is unique in the case of weak states with political cultures that are different from those of the traditional democracies.

1.9 LITERATURE REVIEW

On the debate whether security should be defined from a more pluralistic perspective, Wolfers says specifications are necessary to make national security suitable for 'sound political counsel or scientific usage. David Baldwin (1997), however, argues security must be specified with regards to the agent, person, or collectively those whose ideals must be protected, the values involved, the level of security, the profile of threats, the means for handling such threats, the costs, and the appropriate time frame. Lloyd Pettiford (1996) in Changing conceptions of security argues that security is possibly a more complex idea than is traditionally appreciated. The traditional Realist definition of security in International Relations is comparatively simple. However, Pluralist and Structuralist paradigms highlight that, other correlations exist between various actors and issues, the inclusion of which might reinforce current concepts of security, and that the concept of security is not devoid of political connotation and interest.

According to Baldwin, as it is often said the international system is patriarchal, the traditional explanation of security evolved to represent the most vital issue for the developed Western states. It also became a foremost systematising concept in the field of International Relations. However, there are other schools of thought that looks at security differently. Non-Traditionalist explanations of security and International Relations range from the Pluralist, Structuralist, and post-Modernist paradigms. Their main divergence from the realist thought the realist spectrum of is too narrow, thereby skipping or missing critical issues or factors from the political agenda. Certainly, any efforts to re-conceptualise security will always have political implications. In the after-effect of the Cold War, even developed Western countries have come to the appreciation of, for example, ecological challenges and other issues have become an integral part of the mainstream political and International Relations concerns.

As such, efforts to widen the security concept appear to fit the novel interests of the world's leading states to the degree to which they incorporate environmental issues and the interpretation of justifiable development. The re-conceptualisation security to embrace the environment and development in modes which do not imply the quest for weighty reform of the global political economy meant the apprehensions of the world's most powerful states remain the vanguard of International Relations. From this perspective, the conceptualisation of security may be altering but it remains a concept that can be applied to the developing world but the redefinition remains inadequate for a full grasp of security.

Baldwin, however, warns that the reconceptualization of security to include other concerns than national security requires fundamental structural changes in the political system. And the critical danger in doing so is that the concept of security will become so broad that the distinction between security and International Relations in general will become very blurred since too many new concerns may be crowded into security. Concepts of security according to Realists were advanced for reasons that were valid then but were clearly limited in attempting in explaining the security concerns of the developing world.

Shaibu Mohammed (2016), The Concept of Security and the Emerging Theoretical Perspectives, argues that scholarly discourse on security in International Relations and Security Studies, despite the naysayers, has evolved over time alongside the changing profile of global security threats. Paradigms on security evolved overtime to clarify and every so often justify and legitimize states' activities within security spectrum. The realist paradigm of security before and during the Cold War which fixated on state defense from international threats to

national interests became wider in scope since the end of the Cold War. Discourse on security now embraces expanded issues such as economic security, health security ecological security, food security and human security, among others.

Adam Kamradt-Scot C and Colins McInnes (2012) examine how pandemic influenza has been conceptualised as a security concern that threatens the working of both state and society, and the policy responses that characterised the framing of pandemics as security threats. They observed that pandemics has long been known as a hazard to human well-being. However, for much of the 20th Century, pandemics were not acknowledged as a security threat. In the late 2005, the world created a new United Nations System Influenza Coordination (UNSIC) and the contagion was effectively securitised with weighty insinuations for public policy. They address the conceptualisation of pandemics as a threat and seek to answer what accounts for this momentous mobilisation of resources on a war scale to contain them? They highlight how the conceptualisation of pandemics as a 'threat' to international peace and security has influenced (and possibly twisted) global public policy as reactions towards pandemics. They posit that influenzas as threats to international security has implications for the public health community, governments, and the security community.

Securitisation theory of the Copenhagen School (Buzan *et al.* 1998) serve as the theoretical framework of their work. Buzan *et al*. label their study as to "explore the logic of security itself to find out what differentiates security…from that which is merely political" (p. 5); arguing that (p. 26) that describing an issue as 'security' moves it past the realm of ordinary political discourse and consents that extraordinary response be undertaken. Critically, "[an] issue becomes a security issue… not necessarily because a real existential threat exists but because the issue is presented as a threat" (p. 24). Securitization is the procedure by which this materialises: "the positioning through speech acts (usually by a political leader) of a particular issue as a threat to survival, which in turn (with the consent of the relevant constituency) enables emergency measures and the suspension of 'normal politics' in dealing with that issue" (McDonald 2008, p. 567). It is the portrayal of a topic as an existential threat that brands a speech act a securitising move.

The pivot of securitisation theory is a 'triology' (Stritzel 2007 p. 358, 362) of speech act (the securitising move, Williams (2003 p. 524-8) remarks may employ images and other 'communicative practices' instead of or in addition to words, the securitising agent (who effects the speech act), and the target audience (who consent or contest the securitising move). This

Adam Kamradt-Scot C and Colins McInnes (2012) adopted an experiential split that exist between the securitising act, which is performed by an agent who can communicate with authority of concern; and effective securitisation that is the acquiescence of the securitising move by a conscious and knowledgeable community (the audience) that can take critical action on the crisis issue. They argue that even though the Copenhagen School has offered one of the most convincing explanations of how problems can be effectively mounted as issues of security, major aspects of securitisation theory remain disputed (see McSweeney 1996, Hansen 2000, Williams 2003, Stritzel 2007, McDonald 2008, Ciută 2009).

As an essential contestation of relevance Kamradt-Scot and McInnes is the conditions required for effective securitisation. They are of the believe that the environment, resources, and material events all have an essential role in the securitising process, and as result not all securitising attempts will be a success. Therefore, there are no assurances that categorizing pandemic influenza as a security threat that warrant emergency arrangements would create a path for emergency policy measures. They argue that securitisation is not a binary situation by which an issue is either securitised or not. They argue that securitising attempts actually, entail a range of scenarios where diverse components of the audience may have divergent stances, and along which a consent may swing with time. The securitising move and its acquiescence may be handily measured as definite for heuristic reasons here, but different levels of epistemic communities may react to the securitising move differently within a state or an institution. And that the Copenhagen School is a normative project which underlines the fact that securitisation is not inevitably a necessary state given the undesirable costs of rolling back civil liberties involved in the emergency and repressive policy responses.

The school rather promotes the desire and idea of 'de-securitisation.' As such, there is the possibility of introducing the idea that securitisation may not forever be a linear act by which after a subject has been securitised it will endure. Since the process is principally dependent upon audience acquiescence and appreciation, de-securitisation can likewise ensue. As such, they conclude that the process should be best appreciated as a recurrent event, one where a course of re-justification must occur in order for an issue to stay securitised.

Robert Adams (2020) in "Pandemics and Politics" opens with Taylor's saying that great trials often have small can have very small origins; thus, alluding to the cause of COVID-19 pandemic as fresh indication. Describing the pandemic as a tiny and accidental source of what has become a universal threat. A genetic metamorphosis in a virus that infects human

population. The evolution of such a threat is either natural or accidental and overpoweringly an anti-democratic power. However, its effect and impact on human is calamitous and momentous and have caused deaths more than any known warfare in human history. The contagion has killed millions, made millions unemployed, drastically reduced voyages, triggered states of emergencies, lockdowns, made governments more intrusive, and controlled elections. The pandemic caused diplomatic conflicts among and between states. Causing some to deny medical realities and accentuated trade war between China and the US.

The ability of the UN to contain the pandemic was called into question, as the US berated the WHO. He argues that it is oversimplification to juxtapose the pandemic discourse as autocracy versus democracy. And that natural disasters and plagues have always enlisted controversies surrounding their management. Though WHO has evolved an international public health mechanism for managing epidemics and pandemics, its effectiveness is always possible given the extent of states cooperation. He concludes that containing pandemics requires some very tough and contentious judgements about whether and how to ease some measures and the dangers tangled. Controversies will continue and change can only occur within the experiences gained living with the pandemic. Globally, contentions may arise when a country's activity, or refusal to act, poses risks for other states and their people. Aside the stubbornness of some leaders, there is no repudiating the demanding need to organise and synchronise policies between all levels of regime and across borders (Adam, 2020).

Kofi Quakyi et al (2021), in "Ghana's COVID-19 response: the Black Star can do even better" note that Ghana's early response to the COVID-19 pandemic was acclaimed as one of the best in Africa. It was acknowledged for its inventive testing slant and science-driven political management. But since late 2020, a worrying upward drift of new cases, critical misrepresentations and mortality has been noted. Community-level spread seems to have pointedly spiked. Parallel lapses in contact tracking and community-level testing were also noticed in 2020. Information on COVID-19 risks and risk perception became inadequate and fuelled misrepresentation and poor adherence to infection and deterrence control measures.

In response to the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) pandemic, Ghana developed an Emergency Preparedness and Response Plan (EPRP). Mobilizing national resources and putting in place mechanisms for improved risk and behavioural change communication was a key strategy in the EPRP. Nonetheless, worries concerning COVID-19 misinformation and misconceptions have been expressed on social media. The use of social

media content to regulate the forms, types, and the effects of the misinformation, myths, and misconceptions in Ghana's COVID-19 containment was used in this study.

Tabong and Segtub (2021) in "Misconceptions, Misinformation and Politics of COVID-19 on Social Media: A Multi-Level Analysis in Ghana" revealed the misapprehensions and misrepresentation that ensued in Ghana about COVID-19. Primarily myths were mainly on sources, origins, and susceptibility to the pandemic influenza. It was extensively surmised that Africans or black people had natural immunity against COVID-19. It was held that it was only elderly blacks with health condition such as diabetes, hypertension and the like were vulnerable to COVID-19 threat. These misunderstandings aided the disregard of COVID-19 etiquette among Ghanaians, particularly among the youth. As the transmission of COVID-19 progressed, an extra fallacy developed that the hot tropical climate in Africa subdued viral reproduction and infection. Next, was the speculation that COVID-19 was artificially engineered and serves as a biological weapon targeting Africans to have their population reduced. The usage of local unverified medications and therapies such as the Neem tree leaves (*Azadirachta indica*) were touted as panacea to the pandemic. In the same vein, Akpeteshie (a local gin) was said to have medicinal remedies to prevent transmission of COVID-19. They settle that COVID-19 misperceptions and distortions are extensive and run the length of the course. And that the myths require culturally subtle health communication tactics that take into justificationlocal insights of COVID-19 in order to challenge the flow of flawed believes about COVID- 19 in Ghana.

1.10 METHODS OF DATA COLLECTION

The data for the research will make use of both primary and secondary sources. The primary data will be obtained through administering a semi-structured interview through an online medium (Zoom meeting and telephone calls) interviews with experts from the following agencies the Office of the President, MOH, Parliament, the Security Agencies, United Nations Development Programme (UNDP), WHO in Ghana, NMIMR etc. Targeting sampling will be used.

Questionnaire will also be administered to 50 Ghanaians selected from identifiable public groups. These organizations have been selected because of their accessibility of data and research relevance.

The secondary data will be obtained from both online and offline sources such as the University of Gambia online Library and the Legon Centre on International Affairs and Diplomacy (LECIAD) libraries, which will include books, reports, seminar papers, and other records.

1.11 RESEARCH METHODOLOGY

This study will employ a two-stage formal research methodology. These stages are data collection and data analysis. Qualitative methods using open ended inquiries will be used in the data collection stage. Purposive sampling would be used in the study, which involves identifying persons who have in-depth knowledge of the subject.

Both deductive and inductive methods of qualitative research approaches would be employed for the data analysis stage of this study. The content analysis of the data gathered would use both inductive and deductive methods.

1.12 ARRANGEMENT OF CHAPTERS

1.12.A Chapter One – Constitutes the Introduction of the study.

1.12.B Chapter Two- An Overview of Epidemics and Transnational Security Threats.

1.12.C Chapter Three – The Politics of Managing COVID-19 in Ghana.

1.12.D Chapter Four - Summary of Findings, Conclusion and Recommendations

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CHAPTER TWO

CONTEMPORARY EPIDEMICS AND HEALTH SECURITY

2.0 INTRODUCTION

The recurrence of epidemics and the pervasive threats they pose in today's ever globalising world serve as a new tectonic plague in constraining and reshaping the political, economic, and social organization of the world in unforeseen ways. This chapter relates the changing nature of the concept of security from the hitherto national security to a more inclusive or pluralist conceptualization of security. It examines how ecological concerns became an essential part of contemporary security calculus albeit a contested one. It analyses the recurrence of epidemics, the treats they posed to the world, the securitization of epidemics as international security threats, and the political and other resource mobilization it provoked. It reviews the bolstering and politics of the international public health system's management of epidemics and pandemics. Finally, it recalls the recent Ebola outbreak in West Africa, its management and the lessons learnt.

2.1 THE CONCEPT OF SECURITY TODAY

Security was traditionally envisioned to address international anarchy and its exigencies in a world of rational actors without universally certified regulator. The concept of security tackles problems of the use of force and violence. It involves the contemplation and discernment of threats, how to halt it, fight it, and intermittently use it to intimidate and even employ it fight opponents. It anticipates the situations that inspire or dampen ordered violence in international relations and the conduct of all sorts of military endeavour. International security is ultimately concerned most essentially with the questions of war and peace. Accordingly, peace, war and war making, and their pressures constitute the highest contemplations and responsibilities of states and governments (Freedman, 1998). For these reasons, Max Weber proffered that a state must exercise absolute monopoly on the use or the authorisation of the use of violence within their specified territories. The security of states therefore becomes endangered by any change that might impend that monopoly of violence. Such a threat arises through outside invasion or internal rebellion. However, these are the attributes and expectations of the Westphalian (internally) pacified and robust states, where there is less threat of intra-state conflict, where insecurity is assumed from inter-state perspective.

According to Kalevi Holsti (1996), since the advent of postcolonial states, the community of states has been marked more by intra-state security threats the most significant threats rather than inter-state threats. A paradigm shift which has quickened with weighty consequences for the conduct of international affairs. However, given the mindset of cold war, security was overwhelmingly conceptualised from the inter-state perspective as strategic and irresistible moments of superpower ideological divide ran the writ large. The exigencies of the Cold War fostered cherished formulas of collective security, containment, balance of power, flexible response, and rapprochement (Sachs, 2003). Though, peace studies and international relations pluralist existed and crusaded a more pluralistic thinking of security, realpolitik had its sway.

The end of the Cold War was accompanied by a more radical reassessment of (international) security as the world's security anxieties and profiles changed. Boutros Ghali's *Agenda for Peace*, in the midst of the internecine warfare that that threatened to engulf former East Europe and much of the developing world, qualified sovereignty to foster ubiquitous conceptualisation intra-state violence and enable more expansive intervention to contain them. It also presaged intervention in instances where the security apparatus of weak states became the oppressive tool in the hands of the elite against part of their populations (Ahorsu, 2007). In the early post-Cold War era, new security concepts such as community security, human security, and ecological security developed as threats proliferated. The retooling of the international security institutions and mechanisms were prompted by the complex humanitarian emergencies, accelerated serious human right abuses, internally displaced persons, refuges, vulnerable and besieged civilians and aid workers, proliferation of small arms and light weapons, 'war economies,' and ethnic cleansing that accompanied the civil strife.

The most influential school of thought in the conceptualisation of security at end of the Cold War; however, is the Copenhagen School's securitisation theory. It espouses a broader view of security which classifies inclusive threats such as religious militancy, health threats, human rights, trafficking, and ecological issues in traction with traditional security issues such as disarmament, and arms control as security threats. The saliency of the wider conceptualisation of security rests on increased world population, record advancement in transportation and communication technology, the widespread and rapid movement of people and goods across the globe in record times, increased urbanisation, and climate change and weather erraticism that increased mobility and interaction among people. The ensuing changes created opportunities and new threats, mainly transnational, that compelled states and communities to foster greater collaboration to contain them.

Problems relating to socio-culture, economics, migration, gender, public health, human rights, and the environment, to name a few, have become critical components of the security embodiment, aimed at safeguarding people's rights within nation-states and internationally. The 1992 Rio de Janeiro United Nations Conference on Environment and Development (UNCED) introduced questions on climate change, weather variability, and unsustainable development and its dysfunctional impact on the ecology, people, and society into security thought (Ahorsu and Esseku, 2017). Under the umbrella of human security, the concept of security has progressively been regarded as a universal, inter-reliant, and people-focussed norm that underscores protecting persons from fear and want (UN, 1994). Natural, and direct and indirect anthropogenetic causes of climate change became linked to human activities, ecological degradation, forced migration, crop failures and food insecurity that, in turn, posed transnational challenges to a sustainable world (Mathews, 1989).

The changes that the theorisation of security that the field of security studies underwent, especially the inclusion of ecological and health issues into the security analysis was not without contestations. But Freedman (1998) as proffers, "Defence of the nation against infectious disease is an altogether different problem than the defence against ballistic missiles" but, contemporarily, both traditional and non-traditional security threats must be addressed concurrently by states and statesmen increasingly since non-traditional threats are what the world will be faced with now and hereafter. As Richard Ullman (1983: 153) observes, "the nonmilitary tasks are likely to grow ever more difficult to accomplish and dangerous to neglect."

Some academics, still, have contended that rethinking security must go further to include the ends of security policy. According to Ann Tickner (1994) is security "not only in terms of the internal security of the state, but also in terms of secure systems of food, health, money and trade." She emphasizes "structural violence," which embodies more than physical violence to comprise "the indirect violence done to individuals when unjust economic and political structures reduce their life expectancy through lack of access to basic material needs." A secure society must therefore "promote a viable ecosystem while at the same time working towards the elimination of both physical and structural violence," an elimination that requires "dismantling hierarchical boundaries between women and men, rich and poor, and insiders and outsiders which have contributed to an exclusionary divisive definition of security" (Tickner, 1994: 194).

2.3 SECURITIZATION OF EPIDEMICS AND PANDEMIC

Securitization is hypothesized exactly because of the ends of the concept of security, according to Ole Wæver (1995). Securitization is based on speech acts, typically by ruling elites, where issues, challenges, and adversaries are conceptualised as existential threats to an audience, be it a community or a state. The securitization of speech acts cites "urgency; state power claiming the legitimate use of extraordinary means; a threat seen as potentially undercutting sovereignty, therefore preventing the political "we" from dealing with any other questions" (Wæver, 1995: 51). Securitisation as a concept explores "the logic of security itself to find out what differentiates security from that which is merely political" (Buzan et al, 1998:5) They argue that classifying an issue as security (threat) raises it beyond the jurisdiction of normal political discourse and permits extraordinary measures to be undertaken. Critically, an "issue becomes a security issue… not necessarily because a real existential threat exists but because the issue is presented as a threat" (Buzan et al, 1998:24). Securitisation of issues is marked by "the positioning through speech acts (usually by a political leader) of a particular issue as a threat to survival, which in turn (with the consent of the relevant constituency) enables emergency measures and the suspension of 'normal politics' in dealing with that issue" (McDonald 2008, p. 567). It marks the (re)designation of a phenomenon as an existential threat that brands a speech act as a securitising move.

The Copenhagen School's emphasises the securitisation process. The securitization process is an experiential split between the securitising move, by an actor who can argue with persuasion and authority on the issue; and fruitful securitisation, which is the concurrence of the securitising move by a knowledgeable or conscious community (the audience) which can act promptly on the issue. Despite the feasibility of the securitisation process as one of the most captivating accounts of how issues can be effectively outlined as security issues, many elements of securitisation theory remain in dispute (McSweeney 1996, Hansen 2000, Williams 2003, Stritzel 2007, McDonald 2008, Ciută 2009). Of critical relevance to this study are the settings or requirements needed for successful securitisation. Balzacq (2005, 2011) contexts that setting, and material events perform an essential role in the securitising process. And Kamradt-Scot *et al* (2012) argue that, not all securitising moves are or can be successful. And that, securitisation is not a two-fold situation whereby an issue is either securitised or rejected, but a continuum where diverse elements of the audience may adopt dissimilar views, besides a consensus may swing over time. The securitisation concept is a normative project which

stresses that securitisation is not necessarily a wanted state given the undesirable consequences enmeshed (such as suspension of civil rights and freedoms); instead, it desires to promote ideas of 'de-securitisation' (Kamradt-Scot *et al*, 2012). As such, the progression is best appreciated as a cyclical occurrence in which a process of re-authentication is required in order, for an issue to continue to be securitised.

The securitisation theory is equally criticised as Euro-centred and democratic society related. And that the concept may not work in autocratic or developing countries where citizens are often not involved in decision-making processes (Kavanagh and Singh, 2020). Acharya and Buzan's (2017) on developing countries and international relations offered an ideological basis for securitisation in the underdevelopment and nondemocratic world. As noted by Michael C. Williams (2003), Carl Schmitt's writings, the most influential and controversial legal theorist of the state of exception implicitly underpin this conceptualization of security. The construction of existential threats to the political community does not simply reflect Carl Schmitt's political vision as predicted on a friend-enemy distinction (Huysmans, 1998; Schmitt, [1932] 2007Th). Furthermore, the 'extraordinary means' that securitization legitimizes echoes, the sovereign command of the exception for which Schmitt's ([1922] 2005) theory of the state is notorious. The Copenhagen School sees the danger of 'security' in that it allows governments to suspend legal constraints and democratic principles in the name of security.

Before the advent of COVID-19 and its pressures, health security had placed high premiums on democracy, well-developed health infrastructure, and efficient human and other health resources as the best-placed societies to deliver efficient health security. However, according to Kavanagh and Singh (2020), some countries though considered to be the most equipped and having the greatest capability of responding to epidemic response has failed to respond efficiently to the COVID-19 pandemic outbreak. And that, various techniques through which democracy has been judged to be helpful promoting health security delivery has not worked.

Kavanagh and Singh (2020), among others, argue that the Copenhagen School has downplayed the politics or political capacity necessary for a fruitful securitisation issues and processes. They argue that securitisation of an epidemic imposes revolutionary pressures on governments to enact policies and mobilise resources in record capacity and time. It means rolling back civil liberties. And that the administration of epidemics no longer entails only healthcare delivery capacities, but also political capacities required to mobilise healthcare resources, and emergency political measures to ensure social order and public compliance. "Strong

infrastructure and 'stability' are clearly not sufficient. The state, in all its capacity, must be mobilized through political processes" (Kavanagh and Singh 2020, 5). Health security efficiency is only not technical matters but also a normative and political one. Governments' adoption and public compliance with rigid and unethical measures has consequences for social stability and has political costs for governments' legitimacy. Forced measures, deployed in repressive or semi-authoritarian contexts such as China, have proved to be highly effective in managing the COVID-19. But as Kavanagh and Singh asked, is there an authoritarian advantagein disease response?

Political capacity in managing epidemic emergencies created fall within the remit of policymaking and policy processes. Governments' abilities to force through and achieve authoritarian policy goals involves balancing manifold interests, stakeholders, and even resistance. It tests governments' capacity to sustain trust and legitimacy. These multifarious processes can only be achieved through trust and persuasion (Woo, 2021). Political capacity refers, thus, to the "ability of political systems to carry out the tasks chosen by the nation's government in the face of domestic and international groups with competing priorities" (Kugler, 2018, 1). It is, however, efficient institutions that aid governments' successful deployment of such harsh policies, and decrees (Fukuyama 2004, 2013). Besides state power, it is added institutions and structures of the state that foster collective capacity and contribute to 'social capacity' such as the bureaucracy and courts also participate in certifying larger political capacity (Fukuyama 2011, 2014; (Ostrom 1990, 1994, 1998, 2005; Putnam 1993).

Political capacity or legitimacy capacity in the securitisation of epidemics also include the socio-political credibility and trust of authorities, policy efficiency, information transparency, political communications skills, leadership and flexibility skills, and wider legitimation processes crucial for public institutions and policymakers to guarantee public backing for policies and promote better compliance with rules and regulations particularly within the social domain, political environment, economic sphere, and the security realm (Woo, Ramesh, and Howlett 2015; Gesser-Edelsburg and Hijazi,2020). Greer et al, therefore, argues that securitisation processes, in general, and responses to COVID-19 and their implications can onlybe understood by understanding policy and politics. They conclude that social policies to crisismanagement and recovery, regime type formal political institutions, and state capacity are essential for a successful management of epidemics.

Politics must be understood from the agency and structure perspectives. It entails good leadership and the human resources that a state can command in response to an epidemic outbreak and crisis. But, perhaps, most importantly, the socio-political and economic structure of the state in question matter. The tangible resources, institutions, rules, values, norms, social structure, and political culture, to a large extent, aid or undermine a successful public health response to threats an epidemic outbreak poses to the society. Accountability, transparency, corruption, and communication skills are critically sources of trust and legitimacy that are central to a successful implementation of extraordinary measures to contain epidemic outbreaks. The political culture of most developing countries, especially in sub-Saharan Africa, lack public spiritedness, transparency, and accountability. Public office, even in times of emergency, are often seen and used to enrich oneself with impunity.

Corruption in healthcare schemes is a worldwide harmful socio-political trend that stems from the state's socio-political system and tenets, development, politics, economy, and culture. Corruption and emergencies support each other. As decision-making, procurement, and use of large funds are fast tracked during emergencies and regulative mechanisms are relaxed, a spiteful cycle of mishandling and deeper crisis of corruption is often produced. This, in turn, dents fair, trustworthy, efficient, and impartial responses to crises. The securitisation of epidemics and pandemics and the implementation of authoritarian measures need utmost integrity in the management of health crises and attaining health security.

2.4 HEALTH SECURITY

As noted above, the concepts, language, policies of fields of health and security have increasingly because of the quick transmission and threats infectious diseases and bioterrorism pose to today's world of increased population, globalisation, and interdependence. Statesmen and health administrators have ever more used security discourse tactically in an effort to attract better political attention and resources for containing infectious disease outbreaks. Health (security) has become an integral part of how 'security' is appreciated and practised (Elbe, 2011). The two very dissimilar policy publics have become largely intertwined under the 'health security' rubric. Several names such as national health security, international health security, global health, and human security are used in the extant literature to tag health security and there is no globally accepted definition of health security (Aldis, 2008).

The concept of health security has its origins in the West and focuses on the Western policy communities or the major multilateral institutions. Human security is built on three common arguments that the swift moving nature of communicable disease in a more and more globalising world constitutes an international security threat; that pathogens may be used by terrorists or rogue states as biological weapons against weaponised globally; and, that epidemics and bioterrorism can have social, political, ecological, economic and military impacts which may undermine the stability of communities, societies, and the world (Feldbaum and Lee, 2004, pp. 22–4). Human security conceptualises cross-border spread of deliberate, naturally occurring, or accidental spread of infectious diseases, or major health crises as a threat to international security. The infectious disease security threat mirrors the mainstream policy discourse of the International Health Regulations (IHR) of the WHO, and the Global Health Security Initiative (GHIS) health security regimes (McInnes, 2005, pp. 15–7). The range of infectious diseases are borne out of infectious diseases such as SARS, and HIV/AIDS that are most probable to have impact on population rather than individual health; cause high intensities of illness/death; are critical and short-term rather than long-term in their effects; and swiftly spill over boundaries (Feldbaum and Lee, 2004, pp. 24–5).

States have national health security mindset and projects. However, the consensus is that epidemics and bioterrorism are best managed in collaboration; and that the indifference of one endangers all. There exists a 'statist' perspective that conceptualises health issues as being the same as national security threats; and 'globalist' perspective that lays emphasis on health at the individual phase, and on the degree to which the state is satisfying health needs (Davies (2010). This 'globalist' perspective is typified by the thought of human security. The term health security is one of the fundamental elements of human security (UNDP's 1994).

Human security has two major parts. It denotes safety from such lingering threats such as famine, disease, and repression; and safety from unexpected and injurious interruptions in daily life patterns wherever one is found (UNDP, 1994, p. 23). From the outset, Health security was explicitly identified as one of the components of human security (along with personal, food, environment, community, economic and political). It was consciously designed in the broadest sense to incorporate the full array of infectious and non-contagious diseases and clearly relating health with poverty and discrimination (UNDP, 1994, pp. 27–8). The Commission on Human Security ensuing report echoed this wider concept of health security that 'Health security is at

the vital core of human security – and illness, disability and avoidable death are "critically pervasive threats" to human security' (2003, p. 96).

Surveillance and emergency response to epidemic prevention and outbreak are the most cosmopolitan and enduring measures in containing epidemics. Surveillance effectiveness rests mainly either on domestic health structures such as diagnostics laboratories; regional/national public health authorities; and regional/national data gathering and analysis banks or on border health controls such as health declarations, temperature scanners, quarantine arrangements, among others. The worth of surveillance measures often rests chiefly upon the national health infrastructures but universal collaboration on disease surveillance of states and sharing of relevant data is critical in containing epidemics.

Emergency response activities are likewise reliant on national health system competences. In the developed world, health professionals, emergency services, public communication strategies, fumigation facilities, vaccine/antiviral medicines are developed and stockpiled in capacity to respond to any health emergency whether accidental, natural, or intentional. And are often part of larger disaster readiness plans. However, the WHO undertakes a number of activities in aiding states, especially weak states in developing the necessary and appropriate measures and responses.

The health security agenda just like other development indices is a pointedly twisted one, mirroring the worries of the developed and most powerful states in the world (see Abraham, 2011). And the fear is that health security is subjugated to powerful security interests of the world, with hypothetically adverse ramifications for the health of individuals and developing states. A divide which is turning into a split between the Global North and the Global South.

The leitmotif running through the contemporary International Health Security (IHR) is that it is built on the Global Health Security Initiative (GHSI) meant primarily to protect developed Western states from terrorism threats and later expanded to include exogenous pandemic influenza threats. Mostly exogenous disease threats to the developed world feature highly on the Health Security scale with infectious diseases in the developing world not being accorded the same priority. As such, there appears to be displeasure in some developing states over the notion of global health security, its meaning, and its political consequences. The developing world has to bear much of the costs of certifying global health security, but there are reservations in some parts of the world that these measures are in fact mostly about the fortification of the West.

Since its establishment in 2001, our initiative has progressed considerably and our common goal has remained the same: to reinforce our respective capacities to prepare for and respond to health threats posed by chemical, biological and radiological and nuclear terrorism, as well as pandemic influenza; and to manage concerted action to strengthen global health security (Global Health Security Initiative, 2009).

In the case of GHSI, the answer to the "security from what?" is clear, although the narrative has changed over time. Beginning with a set of very traditional national security concerns, its remithas expanded as pandemic influenza has increasingly come to be recognised by Western security communities as a national security threat (Aldis, 2008). Brazil, for example, objected the use of the term global health security in the WHO Executive Board in January 2008 arguing that there "was no clear meaning of the term and that it enjoyed no consensus among members of the World Health Assembly," and challenged to the use of such discourse in relation to the 2007 IHR (Tayob, 2008).

2.5 INTERNATIONAL PUBLIC HEALTH SYSTEM

2.5.1 Early Forms of Infectious Disease Control

Since humans journeyed from one environment to the other, infectious diseases has been spread and threatened communities and societies. Likewise, measures to contain harmful health impacts of infectious epidemic outbreaks is a frequent across civilisations (Morens *et al*, 2008; Cunha, 2004; Gellert, 1993). The available modes and sophistication of transport largely dictated the intensity and duration of human travels, and often the reach of spread of pathogens during epidemic outbreaks. Traders, adventurers, wanderers, pilgrims, colonialists, military, and refugees had often left infectious disease outbreaks along their routes and destinations, mostly because of the unsanitary situations under which they worked (Cartwright, 1972; Curtin. 1989).

During the medieval era, health inspection and quarantine were extensively used by religious and community leaders to control disease outbreaks (Edmond, 2006; Miller &Smith-Savage, 2006). The advent of steamers marked the speedy growth of commerce and trade during the 18th Century as voyagers and merchants across the world. On their return, they brought with them plagues that caused disease outbreaks in Europe (Herlihy, 1997). In turn, ports, cities, and

nations initiated corresponding measures that, besides treatment and seclusion, sometimes, deprived ships, goods, travellers, and crews of berthing rights as a preventive measure (Gushulak &MacPherson, 2010). The lessons and ethics from the inspection, quarantine, denial of berthing, and other regulative health measures served as the initial cornerstone for epidemic-related global public health services (Parascandola, 1998).

At the twilight of the 19th Century, chief migration destination countries, the US and Canada, promulgated rules that required migrants to submit themselves to thorough medical check-ups for both infectious and non-infectious diseases (Yew, 1980; Lucaccini, 1996; Gushulak &MacPherson, 2010). Confirmed infected immigrants were admitted to hospitals, secluded, or expelled. The detailed health testing regime was however not full proof. Migrants with latent diseases evaded the screening method. Qualified health workers at the ports and the logistics were in short supply and was not sufficient to cater for all travellers. Besides, the screening regime was biased. It discriminated on the basis of status, ticket class and citizenship of the migrants (Stern & Markel, 1999; Gushulak &MacPherson, 2010). As of 1949, there were as many as 13 patchy international agreements regulating the seaport health infectious diseases (Hardiman, 2003). Modern entry port public health regulating regimes such as in Immigration New Zealand, 2005, and Citizenship and Immigration Canada, 2003, are founded on these earlier practices.

2.5.2 Modern International Management of Infectious Diseases

A united global regulatory body on infectious diseases arose in 1949 when the WHO was created. In 1951, WHO announced "The International Sanitary Regulations (ISR)" that harmonised worldwide (the 13 disjointed) agreements to regulate andprotect ports against the circulation of infectious diseases (Hardiman, 2003). From 1951 to 1968, the international sanitary regulations were gradually revised was named the International Health Regulation (IHR) in 1969, to mirror the increased public health needs and goals such the conduct of surveillance and containment of plagues, cholera, smallpox, and yellow fever that the WHO targeted. The 1969 IHR was not comprehensive as non-listed epidemics escaped detection. Neither was the report of budding outbreak of epidemics by member states mandatory nor were all countries privy to data on reported epidemic outbreaks. Most importantly, member states were unwilling to report epidemic eruptions for the fear of being stigmatised and sanctioned with trade, tourism, and travel bans. The 1969 IHR weaknesses

worked against the attainment of reliable data on epidemics and instead fostered fear, suspicion, and exaggerations (Fidler & Gostin, 2006).

The 1969 IRS was restructured in 1995 to foster a more collective and transparent international public health regime to reflect the evolving nature of epidemic threats of ever more globalising and climate change world. The tenets and structures of the 1995 IHR offered a hands-on and early detection and combat of epidemic outbreaks in a day of it being reported via modern communication outlets in conjunction with all stakeholders. It augmented the standards of reporting by appreciating and supporting countries of epidemic outbreaks who may suffer trade, tourism, and travel repercussions. The emergence of the 2003 SARS outbreak forcefully proved the need for a vibrant global public health regime.

In 2005, the IHR was largely reviewed to "prevent, protect against, control, and provide a public health response to the international spread of disease commensurate with public health risks, and which avoid unnecessary interference with international traffic and trade" (IHR, 2005). The 2005 IHR encouraged its members and stakeholders to report all epidemic outbreaks that may spread globally and upset travelling and trade. Members were exhorted to national capacities, and organisations and regions were to sponsor hands-on surveillance and remedies by means of prompt evidence for hazard perception of "PHEIC." As soon as feasible, member states were to develop crucial public health abilities to spot, caution and assess epidemic outbreaks. National capacities were to be mobilised to perform PHEIC responsibilities in collaboration with other state and international stakeholders at the place of the outbreak. Each state has a National Focal Person (NFP) links or communicates with WHO and member states. urges by communicating their knowledge on finding, valuation, practical teamwork, logistical sustenance, and management of financial resources (Article 44 of the 2005 IHR). WHO aids its affected and non-affected members, with skilled staff, organisational, and logistics to build their public health capacities upon request. There are multiple avenues for collaborations such as the WHO regional offices, and joint ventures, (global) NGOs, and intergovernmental organisations, private sector, and international institutions.

Health ministers from 194 member states constitute the World Health Assembly (WHA) that sets its plans. The Decision Instrument in Annex 2 of the 2005 IHR obliges members to alert WHO through their NFP of all cases that qualify as a PHEIC, and the health measures taken within 24 hours of assessment of public health information within their territories. The affected

state must continue to provide WHO with instant, accurate, and complete public health information related to the alerted event. WHO reserves the right, where feasible, to ask any additional information or clarification concerning PHEIC. WHO's Event Management System (EMS) is an apparent and helpful medium that integrates daily inputs collected from tools designed specifically to boost early warning indicators of events of critical public health concern from several data sources. The provided data is fed into the EMS by NFPs, states, and intergovernmental and regional bodies. The EMS helps as a treasury that vets, scrutinises, and informs on detected PHEIC hazards, and aids members cooperate to adopt on the suitable measures for risk management. The EMS, mainly, aids the IHR NFP to share data through the 24-hour Events Information Site (EIS) with WHO and other stakeholders on PHEIC and measures undertaken. Even though, new strains of epidemics are evolving, the basic containment of infectious epidemics is based on the collective experience and lessons from earlier outbreaks. The Alert and Response Operations (ARO), Global Outbreak Alert and Response Network (GOARN), and other administration schemes by WHO in the past engendered the progress of a "payload concept of operations to support functions" (Chu *et al*, 2010).

2.5.3 WHO's Experience in Implementing the Revised IHR

The 2005 IHR was activated on June 15, 2007. WHO, through its regional offices: Office for Africa Regional (AFRO), Regional Office for the Americas (AMRO), Regional Office for South East Asia (SEARO), Regional Office for Europe (EURO), Regional Office for the Eastern Mediterranean (EMRO) and Regional Office for the Western Pacific (WPRO) have appraised member states and regions' abilities, and assisted them developed their IHR main capacities in preparedness to contain infectious outbreak of disease. National and regional capacities are built on the common main tenets of coordinated and cross-sectoral WHO model to attain planned objectives. By 2008, all member states had supplied the WHO with their IHR NFPs, chosen institutions, and three nominated representatives in accomplishment of the 2005 IHR requirements. Member states have also nominated specialists to work on the Emergency Committee that counsels the Director-General of WHO in situations of a PHEIC emergency.

The IHR was operationalised when the pandemic (H1N1) virus was declared a PHEIC in April 2009. The virus was spotted in the US and Mexico, who showed samples with Canada. They conveyed the emergence of the virus to WHO and EIS via their NFPs (Chu *et*

al., 2010). Over 179 countries have since detected the HIN1 in their societies since it was first detected in 2009. The 2005 IHR was once more put to test when the Ebola epidemic emerged in December 2013 in Guinea and swiftly spread to Sierra Leone, Liberia, Mali, and Nigeria to develop into the most extensive Ebola outbreak in history. On August 8, 2014, 33 weeks after the Ebola outbreak WHO declared the epidemic a PHEIC. The Centre for Disease Control and Prevention (CDC) worked intensively with the WHO partners to facilitate the containment, treatment, and prevention of the spread of the epidemic. In-depth case and contact tracing, effectual response to the infected and the community, and pre-emptive interventions were used to prevent the proliferation of the outbreak. Helpful care, protective clothes, water and alcohol-based sanitisers, diluted bleach, interaction and temperature checking, social deployment and culturally apt well-being education became vital in managing the epidemic (source). WHO and the US worked with other governments, other health-related organisations, and non-governmental agencies to stem the Ebola in the sub-region (Source).

The aedes mosquito bites and sexual copulation with the infected saw the outbreak of the 2015–2016 Zika virus (ZIKV) in Latin America and the Caribbean. The Zika virus was declared by the WHO a PHEIC in February 2016. The afflicted persons suffered congenital deformities and neural difficulties. These were suffered by children who were borne by infected mothers. By February 2016, 25 societies in South America, North America, Africa, and Asia were plagued by ZIKV presence. The experiences gained in containing the Ebola outbreak in West Africa thought stakeholders that their collaboration was certain to successful containment of epidemic outbreaks. WHO, states, and health operational partners such as United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Children's Fund (UNICEF), the International Federation of Red Cross and Red Crescent Societies (IFRC), and over a hundred other institutions operated jointly to control the Zika Virus Disease, WHO directed and steered a heightened and uncompromising surveillance, research, and other procedures to lessen the infection rate amongst expectant mothers and ladies of reproductive age.

The narrative above appears a seamless one without major challenges to the implementation of the Revised 2005 IHR. However, though, it reflected a truly worldwide collective and positive public health system of global significance in surveillance, risk valuation and risk administration with boosted national capacities as the key foundations; the perception of cultural, national, and region-specific differences and challenges remain concerning the ends

of the IHR regime. The differences endured and undermined the comprehensive implementation of the 2005 IHR, often reflecting a global North-South divide (Ahorsu).

2.5.4 At Present: IHR vs. COVID-19

The outbreak, and the fast and lethal spread of COVID-19 since 2019 posed the most ubiquitous challenge to the IHR. The COVID-19 recorded unprecedented morbidity and mortality, especially in the developed world that boasts of the most developed heath infrastructure and public health delivery systems in the world. It brought the world to a standstill with economic,political, and social ramifications. The containment of the virus was done through sanitary measures such as handwashing, mask wearing, and use of alcohol-based sanitizers. It also entailed the curtailment of civil liberties such as lockdowns, prohibition of social gathering, and in some circumstances closure of public places and workplaces. It also involved such extraordinary measures such as intrusive legislations, closure of borders and ports, quarantineof travellers and infected persons. Medical procedures such as testing, contact tracing of persons who were exposed to infects individuals, and fumigations were also carried, while theworld raced to find cures and vaccines for the virus.

The response to the COVID-19, initially was lethargic and in the process the preventive mechanisms listed in the IHR failed. The failure was largely due to the hesitance on the part of WHO to declare the COVID-19 as PHEIC early enough, Critically, it appears political pressure from China impeded the WHO's IHR functionality. Taiwan argued that the WHO had enough evidence in December 2019 that the virus was being transmitted from human-to-human but failed to declare COVID-19 as a PHEIC but only did so on January 29, 2020. Member states also failed to adhere to or fulfil the IHR mandates largely due to national discretions and inabilities to comply with the IHR's core competencies, lack of a readily available vaccines and treatment,and the several mutations that the virus underwent producing new strains that were often not amenable to earlier found treatments. States were at clear disadvantages from the outset of COVID-19 due of insufficient funding, logistics, and sheer lack of will. Most states' constrained core capacities upset the worldwide COVID-19 response and containment of the virus.

An analysis of the IHR regime's management of the epidemic demonstrated several divergences of what the IHR had prescribed. The revised International Health Regulations

(IHR) of 2005, in the aftershock of SARS, stressed the logic that the security of individual states is reliant on the security of all (Rushton, 2011). To this end, it frowned upon national self-protection through border closures; and instead, promoted supporting members to contain outbreaks at source. The WHO has steadily counselled against travel and trade limitations throughout the COVID-19 pandemic. But border controls do appear to have been fairly effective as a form of answer to the spread of the epidemic some cases such as in Australia and New Zealand (WHO, 2020).

2.6 The Management of the Ebola Outbreak in West Africa

The overwhelming 2014–2016 Ebola epidemic in West Africa was the largest and the most devastating epidemic outbreak the sub-region suffered. The world did not anticipate the 2014 outbreak of Ebola virus, the sub-region and perhaps the world was not prepared, and the immediate consequence a massive disaster in terms of mortality (Briand et al, 2014). The WHO declared EVD as a PHEIC on a global scale. The virus emerged in Guinea and quickly spread to eight countries in the sub-region. The most alarming aspect of the epidemic and all of them that were managed effectively prompted changes in the way the world reacts to outbreaks and other health emergencies. The most dramatic upshot of the epidemic was the significant mortality it caused. The rate among hospitalised patients was 57–59%, the final records 28,616 people, including 11,310 bereavements. The mortality rate was 40% (Wappes, 2019).

Ebola was a familiar disease pathogen, but the West African strain was different from the Central African strain and there was no known cure for the epidemic. The epidemiological valuation offered important indications that attested that even a recognisable disease agent can manipulate the shortcomings in the health system with ease (WHO, 2014). It was understood that constraints like want of preparedness (Hwang, 2014); common poverty (Chan, 2014); health infrastructure, human resources and logistics restraints (Frieden et al, 2014); poor procedure of contact tracing (Chan, 2014); community unconscious of features an epidemic, and non-community engagement (Bah, 2014); public health unfriendly cultural practices (WHO, 2014); porous and unregulated migration of individuals across national borders (Chan, 2014); hospitals without drugs or vaccine (Marzi and Feldmann, 2014); and, lack of cutting

edge research (Chan, 2014); that are symptomatic of developing countries made the epidemic uncontrollable for the countries of West African's health authorities' capacities.

The 2014 outbreak of EVD again exposed the 'Health for All' aphorism and exposed the challenges Global Security Health is confronted with as a result of the enduring socioeconomic inequalities in diverse parts of the world (Fauci, 2014). Given the threat the Ebola outbreak and spread posed to the world, the developed world and the affected West African states swung into action to contain the epidemic. As a result of the incubation period of the epidemic and the serious concern that it will spread to other parts of the world, especially the West African sub-region, travel restrictions, internally and regionally, were some of the appropriate palliative measures adopted. Many countries imposed or restricted travels to and from the Mano River region.

However, on September 2, 2014, cautioned against travel restrictions on the region and argued that travel bans would prevent much needed experts from travelling to the region, marginalised the affected region and worsen the crisis. It added that what was necessary assurance of effective preventive and curative measures being put in place. On August 8, 2014, a cordon sanitaire was imposed on Guinea, Sierra Leone, and Liberia to forcibly quarantine affected regions where more than 70 percent of recorded infection were found. The cordon sanitaire was replaced with the use of alcohol-based sanitizers, maintaining hand hygiene, and measuring body temperatures at public places, and on major roads.

A motley of Africa's development partners, inter-governmental organisations, research think thanks, and international agencies including the CDC, and Public Health Ontario, Public Health England, WHO, Save the Children, ActionAid, Doctors without Borders, Catholic Relief Service, International Rescue Committee, Caritas, Partners in Health, MAP International, American Red Cross, UNICEF, The OpenStreetMap Team, Project C.U.R.E, Last Mile Help, Samaritan's Purse worked in collaboration to contain the Ebola epidemic. Ghana was used as the command centre for managing the crisis with a collection of Ghanaian workers actively participated in the epidemic management.

The assorted international and regional actors helped educate, build capacity for research, care provision, and provided logistics and protective equipment. According to the MSF (2014) the "Countries affected to date simply do not have the capacity to manage an outbreak of this size and complexity on their own. I urge the international community to provide this support on the

most urgent basis possible." During the early days of the epidemic outbreak, many hospitals and health centres of the affected countries were overwhelmed by the number of patients to be hospitalised, lack of the necessary and qualified staff, fear of the epidemic among patients and health workers; thereby leaving people with other sickness access to healthcare. There was shortage of protective equipment for health workers, a shortage that made the management of the epidemic arduous and prohibited dead bodies to be buried safely. Thus, the Ebola epidemic caused increased demand for protective equipment such as suits, goggles, masks, aprons, boots, and socks that were provided mainly by international agencies, among others.

In terms of treatment, there were no proven Ebola virus specific drugs or treatments. Since most patients suffer from fatigue, fever, dehydration, loss of fluid, and loss of blood, patients, given the diagnosis, are given intravenous fluids, oral rehydration, vitamins, and blood given the circumstances. Research eventually led to Ebola specific vaccines for trials in 2015. In July 2015, scientists announced that the VSV-ZEBOV vaccine trial on Guinea was completed and had shown high efficacy to give protection from the Ebola epidemic through herd immunity. The lessons learnt from managing the Ebola epidemic in the Mano River regions has recently helped in containing Ebola outbreaks on the Great Lakes region of Central Africa.

The WHO's initial handling of the Ebola virus outbreak in West Africa has been criticised as being slow, tardy, rather bureaucratic, incompetent, and insufficient. And that the early debacles led to the spread and not containment of the virus. The WHO Africa regional office, in particular was described as incompetent, lacking credible data, and did not coordinate the epidemic management with other stakeholders efficiently, and that there was confusion of roles and responsibilities. In April 2015, the WHO (2015) confessed very grave shortcomings in managing the epidemic emergency and specified improvements for future crises; "we did not work effectively in coordination with other partners, there were shortcomings in risk communications and there was confusion of roles and responsibilities."

2.7 CONCLUSION

With the reduction in inter-state warfare and other traditional security threats, the lethal threats epidemics and pandemics posed to the world has occasioned in the securitisation of health threats as international security threats. The securitisation processes highlight political elites' ability to label and convince a conscious audience. The successful securitisation is supposed to depend on the acceptance of the audience. But it is clear that such a scenario is largely Eurocentric since in developing countries the public is hardly exercises agency. Nonetheless,

the end of securitisation is to enable a speedy and resourceful operationalisation of a resolve to contain the threat. The containment entails the use of extraordinary measures, often the suspension of civil liberties that are distinctly political in nature. This has seen the emergence of concepts and maxims such as health for all and global health security.

As I have argued above that since health and security are development indices, the predominant actors and influencers will be the Global North with the Global South being at the receiving end given the contemporaneous global structural and functional inequalities. It follows that while the international public health system that is needed to contain epidemics must be all-inclusive to be successful, the developing world will continue to depend on the Global North for its security needs. This logic was evident in the 2014 Ebola Crisis management. Besides, superstition, unhelpful cultural and traditional practices, lack of investment in public health delivery systems, and political challenges are some of the factors that will retard the West Africa sub-region's capacity to contain epidemics.

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CHAPTER THREE

THE SECURITISATION AND MANAGEMENT OF COVID-19 IN GHANA

3.0 INTRODUCTION

This chapter covers the securitisation and management or the politics of COVID-19 management in Ghana. Ghana, as stated earlier, is a weak post-colonial state and in democratic transition that does not command the best of health facilities and health delivery institutions and mechanisms. It has made contingent plans for containing epidemic and pandemic outbreaks, since the exigencies of epidemics and pandemics that stemmed from the 2013 Ebola Outbreak in West Africa. Its securitisation of epidemic threats conforms with equating epidemic threats to national and global threats. A classification that removes epidemic threats from the sole domain and remit of the health sector and places it within the dynamics of transnational security threats. Since March 12, 2020, when the first two cases of COVID-19 were confirmed, COVID-19 was declared as PHEIC.

Ghana was faced with triple trials of maintaining a vigorous COVID-19 response and guaranteeing infections do not spike, saving its economy, and holding free and fair elections in December 2020. Ghana has since instituted autocratic measures within the remit of the 1992 Constitution that nevertheless clawed back many civil liberties. The pandemic had caused more than 455 million cases and 6.03 million deaths as of 12 March 2022, making it one of the deadliest in history. Ghana was not one of the epicentres where the contagion wrought devastation. Both the infection and death rates were comparatively minimal. But the question remains were the relative minimal rates of casualties coincidental or as a result of the efficient containment of the virus? The data for this chapter is sourced from both secondary and twenty-five knowledgeable persons interviewed. The Chapter is organised into the following sections: the securitisation process of the pandemic; the clinical management of the disease -national, regional, and international efforts; the politics of managing COVID-19; Socio-Cultural Perceptions, misconceptions, and misinformation of COVID-19; and an assessment of the securitisation processes and management of the pandemic.

3.1 SECURITISING THE PANDEMIC

The COVID-19 Pandemic, caused by SARS-CoV-2 was first identified in Wuhan, a Chinese city in December 2019, and spread across the world. Initially, many around the world felt the pandemic will either be contained by China or would not spread across the world. The WHO declared it a PHEIC on January 30, 2020, and a pandemic on March 11, 2020, after much delay. As noted earlier, Ghana confirmed its first two cases of the COVID-19 on March 12, 2020 (Agyeman-Manu, 2020). On March 15, 2020, the President of Ghana in an address to Ghanaians enumerated several measures taken to contain the spread of the pandemic. In his speech, the President asked the Minister for Justice and the Attorney-General to expeditiously draft and tender to Parliament an emergency legislation in accord with Article 21(4) (c), (d) & (e) of the 1992 Constitution of Ghana. He likewise directed the Minster for Health to declare COVID-19 a PHEIC in accordance with Section 169 of the Public Health Act,2012 (Act 851) to govern the relevant measures (Communication Bureau, 2020).

The 2012 Ghana's Public Health ACT (851) is largely in accordance with contemporary international public health regime, the 2005 International Health Regulations (IHR) mandated to "prevent, protect against, control, and provide a public health response to the international spread of disease commensurate with public health risks, and which avoid unnecessary interference with international traffic and trade" (Article 2). The 2005 IHR stipulates hands-on surveillance and therapies for hazard valuation and management of PHEIC by its member states (Ken Ahorsu, 2017). As such, Francis Atta, a securitisation expert, argues that securitisation of epidemics, pandemics or PHEIC, entails both international and national dynamics. Because the philosophy upon which 2005 IHR and the declaration of PHEIC works is that "one out all endangered" (Francis Attah, 2022).

The Attorney-General on March 20, 2020, drafted and tendered the Imposition of Restrictions Bill, 2020 (Imposition Bill) to Parliament under a certificate of emergency. Parliament approved the bill into law subsequently after the third appraisal of the bill. The approval in favour of the Imposition Bill was accented to via voice count (Faustina Akwa, 2020). The President approved the Imposition Bill on March 21, 2020. And on March 22, 2020, the Imposition of Restrictions Act, 2020 (Act 1012) (Restrictions Act) was issued in the gazette and became enforceable. On March 23, 2020, the Imposition of Restrictions

Instrument, 2020 (E.I. 64) was similarly published in the gazetteand became enforceable.

The 1992 constitution, among other statutes, contains provisions for the declaration of state of emergency in Ghana predating the declaration of COVID-19 as a PHEIC. The 1992 Constitution stipulates provisions for the declaration of state of emergency in Articles 31 and 32. The 1994 Emergency Powers Act 1994 (Act 472) (Powers Act) is the main law of general claim to regulating state of emergency. Even though, there are other statute provisions, often specific specialised statutes which may be triggered by emergency situations such as the Public Health Emergency of International Concern in accordance with Section 169 of the Public Health Act, 2012 (Act 851). The emphasis here, is not on the legitimacy of COVID-19 pandemictriggered for a state of emergency laws; but on how much the processes, discourse, values, andregulations replicate the securitisation process as stated earlier.

The Imposition of Restrictions Instrument, 2020, on social liberties and imposition of heightened health etiquette, and sanctions in breach of compliance with the stipulations of Executive Instrument 64 of 2020, started with a speech act.

"WHEREAS, on Wednesday, 11th March, 2020, the Director-General of the World Health Organisation declared the Coronavirus disease (COVID-19) a pandemic ... WHEREAS, on Thursday, 12th March, 2020, I, the [resident of the Republic, address the nation on the measures taken by Government in response to the COVID-19 pandemic ... WHEREAS, on Friday, 13th March, the first two cases of COVID-19 were reported and confirmed in Ghana; ... WHEREAS, in ore=der to combat the COVID-19 pandemic and protect public health and public safety, I am satisfied that there exist circumstances which require the imposition of certain restrictions, pursuant to subsection (1) of section 3 of the Imposition of Restrictions Act, 2020 (Act 1012) ... NOW, THEREFORE, in exercise of the power conferred on the President under subsection(1) of section 3 of the Imposition of Restrictions Act, 2020 (Act 1012), this Instrument is made this 23rd day of March, 2020" (Executive Instrument 64 of 2020, 3).

The President of Ghana, being convinced that the COVID-19 threat constitute extraordinary circumstances justified and required the imposition of certain restrictions, imposed restrictions on Ghanaians. Accordingly, "*restrictions were imposed on public gatherings including, conferences; workshops; funerals, festivals; political rallies; sporting events and sporting clubs; private parties and other social gatherings; night clubs, drinking spots and event*

centres; and religious activities in churches, mosques, shrines and at crusades, conventions, pilgrimages and other religious gatherings; and travel to Ghana" (Executive Instrument 64 of 2020, 4).

Apart from the above public meetings being suspended, primary, secondary, and tertiary education and schools were also closed down. It was added that, when practical the Ministry of Education (MOE), in collaboration with the Ministry of Communication (MOC), may run online education programmes. Ghanaians were, however, permitted to carry out private funeral burials with a maximum of twenty-five persons in attendance. Entities rendering services, manufacturing, industrial workplaces, markets, supermarkets, restaurants, shopping malls, eateries, and pubs were to remain operational. Security and essential services were exempted from the restrictions and remained open (Executive Instrument 64 of 2020, 4). The exempted individuals and institutions were bound to observe heightened conditions and etiquette of hygiene in all public places.

The securitisation of COVID-19 somewhat draws its authority from the 1992 Constitution. Though, Articles 12 and 33 endorse the protection and defence of the Fundamental Human Rights and Freedoms of Ghanaians, Articles 31 and 32 confer emergency powers upon the Executive arm of government, under certain circumstances such as disasters, to declare emergencies to maintain public order, ensure essential supplies and protection of life (1992 Constitution, Art 31-32. The power to declare emergencies is vested in the President, while the Legislature exercises oversight authority in approving or rejecting such emergency legislation. The Judiciary is entrusted with the power to adjudicate the rightness or otherwise of cases or individuals who fell afoul of emergency laws or contest such laws. The promulgation of the Emergency Powers Act (Act 472) gave effect to Articles 31 and 32 of the 1992 Constitution. The Powers Act, thus, provides a broad operational framework for securitising extraordinary, plausible, and reasonably justifiable circumstances that merit and constitute emergencies. The Sections 169 and 170 of the Public Health Act, 2012 (Act 851) expatiates on health challenges such as epidemics, and pandemics that threaten the 'national' security of Ghana.

As stated earlier, Act 851 mainstreamed the WHO 2005 IHR that undergirds the international public health regime that demands and encourages its members to pass legislations and build institutional capacities at the state level to promote effective and reliable communications by activating such structures to better maintain global health security against pandemics (Andrus *et al*, 2010; Ahorsu, 2017). Thus, from securitisation theory perspective, under certain

extraordinary circumstances, especially within the context of epidemics as transnational security threat, the need, logic, plausibility, and processes of securitisation does not issue from or fall solely within the remit of the state. While issues such as famine can be securitised by a state, epidemics and pandemics are essentially outside the sole purview of individual members. It can safely be concluded that the 1992 Constitution and Powers Act are progressive and capable of growth and development in protecting its citizens, but it is equally plausible that the Public Health Act, 2012 (Act 851) exemplifies Ghana's fulfilment of its obligations under international law in fighting pandemics.

Again, given the securitisation theoretical assumptions and its critique, the agency of the audience to which the elite or authority securitizes a referent issue as a security is very important in the securitisation process (Kugler, 2018). The leitmotif running through the securitisation theory is much about the ontology of decision-making but more about the conscious, conscientious, and transformative agency of the audience. It explains how securitizing actors through extraordinary measures mobilize their audience by leading a security discourse in order to become adept in implementing extraordinary measures. It requires political processes, capacities, and legitimacy to ensure social order and public compliance with somewhat autocratic measures as management responses (Kavanagh and Singh 2020).

Under the 1992 Constitution, the President acts in engagement with the Council of State to decree a state of emergency by issuing a Proclamation to that effect in the gazette. Thereafter, the President is mandated to straightaway present the proofs and circumstances necessitating the declaration of emergency to Parliament for endorsement or revocation. The emergency declaration has a lifespan of seven days during which Parliament should approve or revoke it within seventy-two hours by a majority vote. Approved emergency proclamations normally remain in force for three months or for a timeframe that may be itemised in the Parliamentary resolution.13 An approved emergency declaration's lifespan may be prolonged by Parliament for a period not exceeding a month at a time. Parliament may also annul an emergency declaration at any time (1992 Constitution, Art. 31).

A main criticism of the securitisation theory is that it is Eurocentric because of the centrality of a knowledgeable, democratic, and effective audience. It follows that in developing countries that are often elitist and autocratic, the public is considered docile, and gullible that cannot serve as an effective agency in the discourse of securitisation (Howell and Richter-Montpetit,

2020; Bilgin, 2011). From the onset, Ghana's legislative efforts to securitise the COVID-19 pandemic were profoundly criticised by interested parties. The minority members of Parliament contested the Emergency Declaration on the grounds that the Act proved inadequate to qualify for an urgent law-making progression. The minority in Parliament also challenged the legitimacy of employing a voice acclamation adopt the bill, given its the urgent nature. Others including lawyers and concerned Ghanaians voiced their dissatisfaction with the process, nature and content of the Emergency Declaration and E.I. 64 on various media platforms. The contestations raise several constitutional and legal issues. Some argued that the procedural propriety of a voice vote in Parliament for emergency legislation was inappropriate (Eunice Brako, 2021).

And some held that the new emergency legislation was unnecessary since the constitutional provisions were sufficient for containing the COVID-19 pandemic (Asiedu, 2021) Others question the time limit for the new emergency proclamation (Brako, 2021) Effectively, the contestations point to evaluating the overall constitutionality of the law-making processes and legislative provisions of the emergency declaration. But essentially defeats the criticisms that developing countries necessarily lack effective agency in the securitisation of pandemics. In the face of COVID-19 exigencies the declaration of a state of emergency is justified. The 1992 Constitution makes room for global pandemic such as COVID-19. Besides, the ubiquitous threat posed by the pandemic satisfies and justifies the rolling out emergency measures under Section 169 of the Public Health Act 851, 2012 for the declaration of a public health emergency.

3.3 THE CLINICAL MANAGEMENT OF THE DISEASE

3.3.1 Ghana's Public Health Preparedness for Epidemics and Pandemics:

Since independence Ghana, apart from cholera, and avian flu, had not experienced the major outbreak of epidemic or pandemic outbreak on the scale of the 2013 West Africa Ebola Outbreak or the COVID-19. However, given Ghana the challenges faced in evacuating millionsof deportees from Nigeria in the early 1980s, it has established institutions such the NADMO to manage similar crisis. Again, in the light ofcontemporary transitional security threats including terrorism, natural disasters and epidemics/pandemics that threaten and buffet the international system, the Ghana Armed Forces Command and Staff College (GAFCSC), Ghana Institute of Management and Public Administration (GIMPA), and LECIAD of the University of Ghana,

for over three decades, have been organizing training and capacity building for the security agencies, health professionals, journalists, and trade unions, among others, under the rubric of conflict and crisis management to respond to disasters and pandemics when they occur (Ken Ahorsu, 2022)

And during the 2013 Ebola Outbreak, the UN's emergency Ebola response headquarters was built in Ghana's capital, Accra. The UN, WHO, and a motley of health Non-Governmental Organisations, and the world leading powers had their teams headquartered in Accra. It served as the hub and open gateway for the teams from January 2014 to June 2016, to co-ordinate their air operations, allowing thousands of Ebola responders, medical and essential supplies, when they were most needed, to Guinea, Liberia and Sierra Leone needed (BBC, 2014). Several Ghanaian health workers were trained and participated in containing and treatment of the Ebola pandemic victims. Although, Ghana did not suffer from the Ebola outbreak, it is noteworthy that the health and public etiquette Ghanaians acquired lingered on and better prepared them on how to respond to COVID-19.

Groundworks were at first driven by the health sector and involved infrastructure, logistics, human resource capacity building and improvement, public education and awareness creation, community, and related sectors arrangements. It also entailed sensitisation, collaboration, and solicitation of media support, and press releases providing updates and information to the public. Training of healthcare workers on pandemic-based existing knowledge, surveillance employing established case definition of COVID-19, and the acquisition and appropriate use of Infection Prevention and Control Personal Protective Equipment (PPE) were some of the basic initial activities (Badu Sarkodie *et al*, 2021).

In anticipation, regional and district levels' preparation and response plans for public emergencies were based on IHR 2005 stipulations, and Public Health Emergency Management Committees (PHEMCs) and rapid response teams were revived, trained, and activated. The National Technical Coordinating Committee (NTCC) made up of international organisations like WHO, national research institutions like the NMIMR and School of Public Health at the University of Ghana, Ministries, Departments and Agencies; and the operational arm of the NTCC, the Emergency Operations Centre (EOC) were activated to play a direct rolea direct role in containing the exigencies of COVID-19. The EOC was mandated to oversee surveillance, laboratory, case administration and risk communication. The NTCC coordinated

the preparedness and response to contain COVID-19; while the EOC was responsible for the execution of preparedness and response strategy at the national stage. The PHEMCs and Rapid Response Teams (RRTs) carried out the functions of the NTCC and EOC, in regions and districts with daily meetings (Badu Sarkodie *et al*, 2021).

Ghana adopted the extreme case definitions for COVID-19 to reduce the hazard of missing some cases based on the WHO counsels. A health statement form was modified from the Ebola Virus disease (EVD) form for use at all entry ports. Correct testing supplies were procured to enable the diagnosis of COVID-19 cases in Ghana; and other logistics like PPEs, thermal scanners, and non-contact thermometers were also provided. The fast tracking of COVID-19 antigen test approvals by Ghana's Food and Drugs Authority enhanced and expanded testing capacity beyond Polymerase Chain Reaction (PCR) testing. The Africa Centres for Disease Control and Prevention (ACDCP)introduced the use of antigen tests in COVID-19 screening and clinical diagnosis, which can be modified to Ghanaian context (ACDCP, 2020).

3.3.2 Public Health Delivery Facilities

At the onset of COVID-19 in China one of the major concerns for Africa was its limited health infrastructure and poor health delivery system. In Ghana, when the first two cases of COVID-19 were diagnosed, the NMIMR and the KCCR were the only two laboratories that could test for and verify the COVID-19. To reduce the shortfall given the rising cases and need for a lager testing, other laboratorieswithin and outside the health sector, such as the VSD laboratory supported the testing and reduced the delaying time between sample collection andtesting. In addition, private laboratories were likewise evaluated and ascribed to provide testingfor COVID-19. Their inclusion augmented the capacity for testing and pointedly reduced the waiting period. The number of laboratories capable of PCR testing for COVID-19 increased from 2 to 16 by April 2020. The National Public Health and Reference Laboratory (NPHRL),the Council for Scientific and Industrial Research (CSIR) laboratory, the NMIMR laboratory,VSD laboratory and 4 private laboratories (Abraham, 2022) located in Greater Accra were utilized. In the Ashanti region were the KCCR and the Komfo-Anokye Teaching Hospital (KATH). In the Volta Region was the UHAS, and in the Northern were the VSD laboratory and Zonal Public Health Laboratory.

The National Laboratory in the Western Region also became operational. And in the Upper East Region the Navrongo Health Research Centre Laboratory was accredited to test for COVID-19. Six GeneXpert sites were instituted at Cape Coast Teaching Hospital, and Effia Nkwanta, Sunyani, Bolgatanga, Wa Regional and Sefwi-Wiawso Municipal Hospitals (Ampofo, 2022).

In Ghana, human resource capacity for PCR testing increased significantly as part of the laboratory component response. The NMIMR and the KCCR trained Biomedical scientist and other laboratory staff to provide PCR testing services. At the national level, a laboratory network was also developed, with a Coordinator assigned to oversee the work, including the management of logistics for sample collection, testing, and transport. Notwithstanding the numerous valuable activities undertaken as part of health sector preparation and answer to the COVID-19 contagion in Ghana, various shortcomings were acknowledged. Key among the trials were intermittent scarcities of PPEs, geographical limits in testing for COVID-19, tardiness in receipt of COVID-19 tests, inadequate staff to run treatment centres and shortage of COVID-19 laboratory reagents.

3.3.3 Clinical Management of the COVID-19 Pandemic

On March 12, 2020, when the two first cases of infection were confirmed in Ghana, and a Public Health Emergency of National Concern (PHENC) was declared, pandemic management mechanisms such as enhanced surveillance, case detection, case management and contact tracing in addition to laboratory testing culture, clinical practices, public health education, and heightened sanitation etiquette were employed to prevent, contain, and treat COVID-19 infections.

According to Prof. Binka (2021),

"…despite the availability of a credible framework to handle the pandemic, resources, funds and logistics were not readily available at the onset of the COVID-19 outbreak. These weaknesses or limitations were equally experienced by the developed countries such as the United States of America… there was therefore the pressure to acquire funds and the necessary logistics, expand facility capacities and develop and adapt human resources abilities."

As noted above, an aggressive endeavour to increase laboratory capacities were carried out. It also necessitated recruiting and retraining of relevant health workers to work 24/7 to cope with the exigencies of the pandemic. Apart from the health professionals, an ancillary workforce

was recruited and trained to handle logistics, sample handling and transportation. Laboratory testing policy, guidelines and job-aids were developed, and staff were trained on them for prompt use (Bediako, 2021).

The containment of the pandemic, primarily involved testing based on case definition, testing those infected persons had contact with, close contacts, heightened contact tracing, and screening of vulnerable communities. Prioritised testing of suspected cases or persons exhibiting COVID-19 symptoms, contacts, exposed health workers, students and teachers, and vulnerable groups were later screened and tested as part of the laboratory response plan. The testing strategy initially entailed PCR and two-fold exit testing to assess convalescence and release from the treatment and quarantine regime. Subsequent to the review of the National discharge and recuperation policy, the mandatory exit testing was stopped. The pooling method was originally espoused but was stopped when the test outcomes returned very high positive results.

When air travel was reopened, a controversial swift diagnostic testing at Kotoka International Airport (KIA) using Immuno-fluorescent assay technology was instituted. Part of the laboratory response initiative for the re-opening of the airport involved assessing the Rapid Diagnostic Test kit approved by the FDA in partnership with the NMIMR. An overall of 70 test kits were evaluated at the close of December 2020. All 70 kits were not suitable for COVID-19 testing in Ghana since they did not meet the set national standard.

The abandonment of the mandatory exit testing, and the relaxation of contact tracing, and the institution of rapid testing regime at the Kotoka International airport were variously criticised. Some of the respondents interviewed argued that the cessation of the mandatory exit and mass testing were not entirely based on scientific evidence. But due to the unwillingness of the authorities to pay workers the agreed upon remuneration for contact tracing and other forms of surveillance (Respondent 3, 2021). It was alleged that the scaling down of testing was due to the anticipation that infection rates would not upsurge, and for that matter funds could be conserved (Respondent 1, 2021). According to the Quakyi *et al*, (2021) the reduced testing in late 20020 based on GHS decision to concentrate on testing and tracing symptomatic patients seeking hospital treatment, but at the cost of community tracing (See also (Arku, 2021). As a result, the contact tracing regime was lowered to almost non-existence in part of Ghana. many COVID-19 healthcare workers like institutions witnessed inconsistent and

inadequate PPE supplies (Welle, 2020). And many workers were not paid their allowances and they threatened to go on strike to press home their demands (Tawiah, 2021). Meanwhile, the infection rate increased dramatically in January 2021 as more of the UK contagious strain found it ways increasingly and dominated the COVID-19 transmission (Darko, 2021). Under these circumstances healthcare workers were highly vulnerable to infection; and besides, there is very compensation for the risks they were exposed to.

The increase in the UK strain infections and its lethality resulted in a rebound in COVID-19 testing in January 2021. It also resulted in greater care-seeking for COVID-like symptoms at health institutions, and larger demand for testing at private laboratories. The upsurge in demand for COVID-19 testing and certification were largely due to travel requirements, and the revival of contact tracing in mainly urban centres. In August 2020m a seroprevalence research was carried out in Accra and adjoining communities revealed that one in five residents in that catchment area of over 1 million people might have earlier been infected with COVID-19. When the study report was released, Ghana's collective national case sum was still less 50,000. Regrettably, the testing regime and rate remained fundamentally unchanged (GHS, 2021). According to Prof. Binka (2021), Ghana's COVID-19 testing regime, and essentially the COVID-19 management were essentially prioritised to cure rather than prevent and contain the pandemic. He argued a preventive oriented regime should necessarily involve a more proactiveand expansive community outreach and testing.

In clinical tradition, there are difficulties concerning the turnaround time for COVID-19 sample gathering, investigation and reporting. Despite the fact that the number of public testing facilities offering free testing has increased significantly across the country, there remained significant bottlenecks. There were recurrent scarcities of testing reagents and other logistics. There was high persistent testing load resulting logjams that pointedly delayed the release of results and muddle timely clinical decision-making. The holdups also create an added threat to community transmission containment. Irrespective of symptoms, some persons may never quarantine until they get a positive examination result (Sawer, 2021). Besides COVID-19 health worker well-being and payment issues, the health delivery infrastructure suffered critical inadequacies in terms of availability of beds, particularly for intensive care patients. A study surveyed on 25 health facilities throughout Ghana, all 23 public regional and teaching hospitals inclusive revealed that only 10 of the 23 hospitals had standard intensive care units (Siaw-Frimpong *et al*, 2021).

A respondent responding to non-prioritisation of health over peripherical issues has this to say:

"It's completely not right because life they say matters than any other thing and should always come first. Ghana did not have enough PPEs (based on the cries of health workers), hospital facilities were overcrowded, health workers were exhausted, and COVID-19 cases were mismanaged, non-covid-19 related heath cases were relegated or given no or low attention. Even though, the government was considering the livelihood of the citizens, one cannot dispute the fact that health is wealth." (Cited in Kutor et al, 2021).

The president reopened schools on January 18, 2021, after students and parents were reassured that educational facilities and their environments were disinfected and that measures were in place for infection outbreak controls (Presidency, 2021). When the schools were reopened, however, the necessary robust information and sensitization on COVID-19 and its mode of transmission and the danger it posed to children were not forthcoming. Besides, intermittent fumigation was sadly inadequate for averting COVID-19 infections. The Ghana Education Service (GES) published directives on COVID-19 transmission control for schools that assured that government's provision of handwashing gadgets, hand-sanitisers, and face masks. However, the PPEs were hardly supplied, and even when supplied they came in tardy and in sufficient supplies (GES, 2021).

Head of schools had to contend with overcrowding in class and dormitories. Parents were banned from visiting their wards in school for the fear that visitors to school will transmission of COVID-19. However, cluster of schools and students were infected testing positive from on-campus transmission (Ansah, 2021). Regrettably, National COVID-19 data released by the GHS Disease Surveillance Department are arranged according to age differences. Therefore, relegating children and missing opportunities to sensitise stakeholders and the general public about the pandemic's impact on children (Quakyi, 2021).

The entire COVID-19 regime lacked compliance particularly within the political class that were expected to be more discerning. There was a near-disaster in Parliament, that highlighted not the impact of lack of clarity on infection control as to who the pandemic restrictions apply to, how the pandemic controls should be applied, and how and who the restrictions should be enforced. MPs refused an effort to have them screened in Parliament. And those who alleged they have been tested were hesitant to disclose their status. More than 60 Members of Parliament at first refused to be tested. Worse still, several MPs that tested positive declined to be quarantine and persisted to congregate in Parliament (Kokutse, 2021). The Parliament's

disregard for infection control lasted for more than two weeks before its shut down for 21 days. This was after 17 infections were reported among the 275 MPs. And 151 of the 500 staff tested positive as of February 10, 2021 (Kokutse, 2021). The uncooperative attitude and hesitant handling of COVID-19 transmission in Parliament caricatures challenges workplaces had in managing and containing worker infections.

Ghana has been given 13. 8 million doses of vaccines. 4.87 million Ghanaians are fully vaccinated constituting 15.7 percent of Ghana's population. Ghana had aimed to vaccinate 20 million of its 32 million resident population by the close of October 2021. Most of the vaccine available in Ghana were sourced through multilateral agreements and bilateral deals. Ghana was the first developing country to be donated vaccine shipment from the COVAX facility. It received 600 000 Oxford-AstraZeneca vaccine doses on February 24, 2021. From March 2021, it has been administering doses to selected priority groups covering frontline healthcare workers, security staffs, individuals over 60 years old, those with health issues and government officials.

The vaccines have since been made available to all in the exception of, pregnant women and children. A study carried out on vaccine hesitancy conducted in August 2020 before any COVID-19 vaccines had been permitted, and a second round was conducted in March 2021 when the Oxford AstraZeneca vaccines had reached Ghana show that hesitancy pointedly decreased between those two periods from 36.8% to 17.2%. However, a June 2021 report included 1,295 Ghanaian respondents, show a significant increase in hesitancy from 17.2% to 28.5%.

3.4 MISPERCEPTIONS ENGENDERED DURING THE COVID-19 MANAGEMENT

Misconception and misperception were some of the reasons for misinformation on vaccines, the high vaccine hesitancy and low vaccine acceptance. They early misperceptions and myths were flourished about every aspect of the COVID-19. The perceptions were mainly peddled through the use of the social media, especially Facebook, and WhatsApp. When the pandemic broke out in China, the two most popular myths and perceptions were that the pandemic does not attack blacks since they have natural immunity against the virus, and that the tropical hot environment insures against the spread of corona virus, and thus prevents the virus from spreading to Africa. An additional misconception was that COVID-19 attacks only elderly people while young persons were less vulnerable to the virus. However, as the COVID-19 virus

evolved, these myths were proved to be false. The virus spread to Africa, Black in Europe and North America, as well as Africa were infected and suffered lethality, so did young men just as elderly men got infected and died of the condition (Tabong and Segtub, 2021).

In Ghana many young, energetic, healthy, and often athletic persons argue that only people with health conditions like high blood pressure, diabetes, and asthma were at risk of being infected by the virus. In terms of COVID-19 infection prevention and treatment, unapproved remedies such as drinking of apple cider vinegar, eating of garlic, inhaling steam made from boiled neem tree leaves, and drinking Akpeteshie alcoholic drink would both prevent and cure individuals of COVID-19 transmission (Tabong and Segtub, 2021).

The myths and perceptions on the origins and the utility of COVID-19 even assume geostrategic dimensions. The discourse is that the virus was created in laboratories in China and sometimes, held to the handwork of the US and/or billionaires like Bill Gates have complained about the unwieldy world population and its unsustainable anthropogenetic effect inducing dysfunctional climate change and the need to reduce the world population. The argument is that the virus was synthetically created to reduce the global population. The same logic is applied to the application of vaccines as panacea to COVID-19. This argument is extended to the conclusion that vaccines are primarily meant to reduce Black population. There are other multiple myths and perceptions about the virus that amounts to the politics of COVID-19 dynamics (Ken Ahorsu, 2021). And it must be added that Trump's gimmicks about COVID-19 in the US did very little to disabuse negative perceptions about the COVID-19 and its vaccines (ibid).

3.5 SOCIAL INTERVENTIONS AS PART OF COVID-19 RESPONSE

Given the fact that Ghana is a developing country, and most Ghanaians live on the daily earnings that were disrupted by the COVID-19 pandemic and the restrictions imposed to contain the crisis, the Government of Ghana (GoG) introduced numerous social interventions to mitigate the adverse COVID-19 impacts, as part of the response efforts for COVID-19. Providing food to the needy in Greater Accra and Kumasi suburbs were among the many social interventions. According to the Finance Minister, Ken Ofori-Atta, the mid-year budget revealed that the government spent GHS54.3 million ($9,383,487) on cooked food for about 470,000 families within Accra and Kumasi metropolitan areas during the three-week COVID-19 lockdown. The government also gave water to Ghanaian for free from April 2020 to

September 2020. Public pipe-borne water stands, and water tanker distribution services were offered to Ghanaians. The government also discounted the cost of electricity to consumers at 50% starting April to December 2020.

Healthcare workers were exempted from paying tax on their monthly remunerations from April 2020 to December 2020. The COVID-19 frontline healthcare workers' salaries were topped-up with 50% of their basic pay from April to December 2020. Forefront healthcare workers also benefited insurance cover of up to GHS350,000 and those in Accra-Tema, Kumasi, and Kasoa also enjoyed free transportation to and from work.

3.6 PARTNERSHIPS AND COLLABORATION

Several private health facilities in Ghana, multilateral institutions, and bilateral arrangements were involved in the management of public health emergencies that promoted significant improvement in Ghana's management of the COVID-19 threats and exigencies. The private sector's aid to Ghana's response COVID-19 exigencies stretched to building the pioneer Ghana Infectious Disease Centre (GIDC), a well-equipped and furnished wholly from funds from the private sector. at the Ga East Municipal Hospital. The private sector handed it over to the government to use in managing the COVID-19 crisis and potentially for future management of pandemic outbreaks.

Non-governmental organisations and Inter-governmental organisations were also engaged in the public education initiatives for COVID-19, including the design and dissemination of information on COVID-19 care, providing billboards, and utilizing other communication channels as traditional and social media. The private sector donated meaningfully to the Ghana COVID-19 National Trust Fund founded by the government to offer a channel for resources from the non-governmental segment in support of the government's energies concerning COVID-19 response. Resources marshalled by the Fund have been valuable in the COVID response backing up various actions, including sourcing of PPEs and other vital logistics. The World Bank, IMF, the EU, the US, Germany, the France and the UK, among others,made both monetary, vaccine, and other COVID-19 logistics contribution to Ghana.

3.7 THE POLITICS AND DISCOURSE OF MANAGING COVID-19

The inception of COVID-19 epidemic and its exigencies was at a time Ghana was preparing to run its perennial Presidential and Parliamentary Elections in December 2020. Ghana's Fourth Republic political scene is dominated by a bifurcation of the NPP and the NDC as the two dominant political parties. The contemporarypolitics of Ghana has been highly supported and frenzied. Ghanaians, and daily discourse are thoroughly polarised along the NDC-NPP divide. The extant patronage politics, appointments, access to services, resources, and contracts in Ghana are often subjectively and politically determined, rather than being objectively determined by politicians. The hyper-competitive environment had many posers for the management of COVID-19 in Ghana.

Will the semi-autocratic laws that the COVID-19 imposed emergency dictated be altruistically promulgated just for health expediency? Or the rules will be socially engineered to uneven the political playing field to favour the ruling party and its supporters? Will the national public health managing policies designed to contain the pandemic mirror or comply with the IHR 2005 regime and other global concepts of best practices in managing the crisis? Will both national and international resources mobilised for fighting the COVID-19 pandemic be diverted for political expediency? Will the opposition accept the COIVD-19 regulations objectively or criticise COVID-19 regulatory policies objectively and constructively? Will they perform their COVID-19 roles selflessly? In Ghana's political culture, often, politicians, administrators, and workers place personal gains, even if illegal, ahead of altruism and efficiency. Relevant to this study, the politics of COVID-19 management, in the context of the December 2020 Elections, political capture and corruption drove inequality and thoroughly influenced the management of the pandemic.

Ghana's bi-partisan political divide and its influence over decision-making both inside and outside its socio-economic and political institutions (Oduro et al., 2018) became thoroughly manifest from the inception when the NDC presented a technical team to the government to help in containing COVID-19 transmission and management. However, several intentions were read by NPP sympathizers into this singular act of the NDC forming a technical team to advice the government. In an interview the Member of Parliament for Juabaso Constituency and member of the NDC COVID-19 team, Kwabena Mintah Akandoh (2021), he said the NDC formed the COVID-19 team because the NDC government had gained invaluable experience in managing pandemics when Ghana served as the hub for managing the pandemic during the 2013 Ebola outbreak. The NDC felt it had a national responsibility to contribute containing the pandemic (Akandoh, 2021). However, according to Yao Buabeng Asamoah, the head of the

NPP communications, the NDC was up to mischief and to gain cheap political points by presenting the incumbent government with a COVID-19 team (Asamoah, 2021).

A respondent from the MOH, Ghana, said the government was of the opinion that accepting the NDC COVID-19 team would have meant that the NPP government was incompetent in managing the pandemic crisis. He continued that while the COVID-19 pandemic posed a huge risk to lives, it also created a large economic opportunity for resources, contracts, and financial gains. And that the NDC would have gained vital advantage and influence on how the government spent both nationally and non-inclusion of the NDC team inthe government's management of the COVID-19 crisis bordered on questions of transparency and accountability (Respondent 3). The non-admission of the NDC was a political decision since the government felt the utility of the NDC team in the daily COVID-19 decision-making would be putting sand in the pocket of the NPP to keep trail of how COVID resources are expended.

The NDC COVID-19 team, nevertheless, played many roles in the management of the COVID-19 crisis in Ghana. It criticised, advised, and supported the government's management of the crisis. In February 2020, Ghana issued a 41-year bond and successfully raised US$3 billion in the international debt capital markets. The deal covered US$1 billion 14-year WAL and US$750 million 41-year WAL priced at a coupon rate of 6.375%, 7.875% and 8.750%, and US$1.25 billion 6-year Weighted Average Life (WAL), (CitiNews Room, 2020). And the government planned to use the US$ 3 billion Eurobond to support Ghana's containment of the pandemic. The NDC called on the government to use Bank of Ghana's reserves pro-poor policies to support individuals and companies worst hit by the coronavirus pandemic. The measures projected comprise rent subsidies and freezes, delay of tax payments and incentive packages for companies.

According to Tabong and Segtub (2021), trust, legitimacy, transparency, satisfaction, and participation, especially in the management of information, is essential in evolving a public health regime for managing pandemics. They argued that the NDC-NPP divide engendered the spread of conflicting views about COVID-19 in social media. The NDC were the first to broach concerns about government's running of information and communication concerning COVID-19. A lot of information was broadly spread in social media that government was registering high numbers of infection to get World Bank COVID-19 relief fund.

"There is generally mistrust between the incumbent government and opposition and this is fuelling the misconception about the condition. The opposition constituted a parallel COVID-19support team. So, you have two groups of people providing different information. So, the ordinary Ghana become confuse and rely on the infodemic in social media which largely are misinformation" (quoted in Tabong and Segtub, 2021).

On the hand, as the pandemic crisis evolved, government was criticised, in widely circulated social media posts, of underreporting the number of COVID-19 infections, recoveries, and death. It was speculated that the government was under-reporting the number of cases, recoveries, and deaths to show that Ghana was overseeing the pandemic threat efficiently. The zenith of this occurred on May 5, 2020. During a press conference, with Ghana's overall cases confirmed were 2,719 and 294 healings, and 18 deaths. It was broadcast by the GHS that the country COVID-19 cases had gotten to its peak in the country:

"We are not out of the woods yet. We are at the peak of the curve, but yet to come down, and we urge Ghanaians to adhere to the preventive measures put in place so that we can see an early decline in infections" (GHS cited in Tabong and Segtub, 2021).

However, many health experts and the opposition party disagreed with the position of the GHS. An interview that was granted a health expert with Centre for Democratic Governance (CDG) which was widely circulated on social media states:

"The fact that you are testing more means you will identify more but it also means the disease is spreading more and that's why in our opinion we are nowhere near our peak."

Many attributed this report of Ghana reaching the peak of infection to political propaganda. The manipulation was to help massage COVID-19 transmission statistics to ease the restrictions imposed by the government to pave the way for the NIA to complete the mass registration and issuance of the Ghana Card, which's issuance and utility as the authorised identification for qualification for registration as a voter. The ploy to ease the restriction was also to enable the Electoral Commission (EC) to conduct the new voters registration exercise for the 2020 presidential and parliamentary elections. An interviewee stated as follows:

"You see the myth that COVID-19 infection had peaked in Ghana was simply a political decision to enable the government to ease the restrictions for the voters' registration. when some of us were interviewed and we indicated Ghana was not near peaking, we were attached

but we have all now seen that the announcement had no basis. How many times have we peaked since the first announcement?" (IDI-17).

It follows that in developing countries such as Ghana, securitisation of pandemics and the designing of national public health regulation in compliance with IHR 2005 stipulation may not be solely influenced by the threat of a pandemic and responsibilities under international public health exigencies but also influenced by political expediencies.

Ghana: NDC COVID-19 Technical Team Donates PPE to Korle Bu Teaching Hospital (KBTH) Cardio Centre.

Despite the NDC-Technical Team on COVID-19 donating quantities of PPEs, they spent time and resources in educating the public to abide by the COVID-19 regulations. Its 2020 Elections Manifesto outlined how differently it would manage he pandemic when voted into power (NDC Manifesto, 2020). It also presented PPEs to hospitals throughout Ghana to help them fight the pandemic. The items included gloves, nose masks, protective clothing, medical boots, electronic thermometers, and detergents, among others. The donations were to motivate the health workers in their determination in the fight against the virus (Djokoto, 2020).

3.8 COVID-19 & ELECTION 2020

A major political debate during the COVID-19 outbreak was whether to go ahead with the running of the 2020 Elections, and the compilation of a new voters' register. The impact on Ghana's 2020 General Elections on Ghana's COVID-19's management cannot be overstated. Initially, the concern was that the social gathering and other activities that attend political campaigns and subsequent elections would spike COIVD-19 transmissions. Although stakeholders, however, agreed that the elections must come off all the same because postponing the elections posed constitutional challenges of *inter-regnum* to Ghana. Ghana's EC reassured the stakeholders and electorates that the COIVD-19 protocols would be adhered to ensure the non-spread of the virus during the Elections. However, a controversial issue raged on even before COVID-19 cases became manifest in Ghana. This was the EC's adamant resolution, contrary to the earlier tradition of adding new qualified voters to the existing voters' register, to compose a new voters' register. Some CSOs and the NDC earlier contestation of the idea of a new voters' register was bolstered by the uncertain situation

created by the pandemic and the heightened fear of spreading the pandemic (Agbele and Saibu, 2021).

Another controversy that emerged during the uncertainties and dangers posed the 2020 Elections was the rejection of earlier voter's card and the proposal to use the Ghana Card and the passport as the accepted identifications for qualification to register as a voter. The Ghana-Card scandal brought the saliency of COVID-19 ethics and regulations, and the political expediency of the ruling NPP and the EC onto a headlong coalition. Notwithstanding the lockdown in Accra, the NIA carried out a mass registration of persons in the Eastern Region, a stronghold of the ruling NPP. Although the Eastern region was exempted from the lockdown, majority of Ghanaians prefer voting in their places of origin or in Ghanaian parlance, theirhometowns. Since there was no ban on travelling to the East Region from other parts of Ghana the mass registration would help increase COVID-19 transmissions. The impunity with whichmany assembled to register for the Ghana Card drew a backlash from the well-meaning Ghanaians. The fear was that people could move from the epic infection zones such as Accra and Kumasi and spread COVID-19 infection to the Eastern Region. The criticisms occasioned a temporary pause in the registration for the Ghana Card (Rfiq Raji, 2021).

The backlash caused by the continued Ghana Card registration and the lull in registration that it engendered, many expected the EC to shelve its strategies to assemble a new register. For without the Ghana Card to register for the new voters' card coming handy, the election timelines were expected to be delayed. However, the GOG lifted the ban, andthe EC, despite all the condemnation voiced by both NGOs and the NDC, publicised June 30 to August 6, 2020, as the new registration process dates (Asante, 2020). The EC's key decision that the pandemic forced was an indeterminate holdup of the earlier start date, April 18, 2020, for the compilation of the new voter register. The suspension became essential because people physically assembling at designated registration centres to register could trigger mass infections. Yet the suspension deepened existing apprehensions regarding the EC's capability to compile a new voter register early enough for the December elections in December (Asante 2020). Besides, the voters registration exercise became susceptible to a standstill in the worldwide supply chain of digital equipment as a result of COVID-19 lockdowns around the world. This implied that suppliers of the new Biometric Verification Machines (BVMs) were most doubtful to allocate these machines in a timely style (Aikins 2020).

With regards to public health concerns, the EC offered guarantees that registration would be steered through stringent devotion to safety protocols stipulated by the GHS and the MOH, (Electoral Commission 2020b). In conformity with the stipulations, the Commission established and drew the safety regimens to be followed. Registration centres use of PPEs (Electoral Commission 2020b). Voter registration took place matching theamended timetable. Most of the care measures were observed, but there was large non- compliance with the required social distancing at most registration facilities. The rife disrespectof social distancing made most observers labelled the registration exercise as a COVID-19 broadcast exercise (Modern Ghana 2020).

Political campaigns in Ghana are mostly done through face-to-face campaigns (Agbele 2020b). As such, the outbreak of a virulent global pandemic in the run up to an election year seriously poses health risks in the course of full-blown campaigns (Asplund et al. 2021). At the initial stages of the government's COVID-19 response, it was palpable that it was going to be difficult to contain the spread of the virus, in tandem, the multiparty political campaigns. The temptation to campaign vigorously to win the campaign was a temptation worth the risks in Ghanaian political culture. Many judged the government's lifting of the ban on communal worship on June 5, 2020, as a façade behind which parties, chiefly the NPP, can hide to hold primaries and campaign (Africa news 2020). Schemingly, there was no limit placed on the number of people permitted to assemble for the 2020 political campaign.

Until the outbreak of COVID-19, electoral campaigns in the previous years were focussed on the economy and how the incumbents had delivered efficiently and effectively on promised programmes. The incumbents' campaign and political advertising in 2020 however shifted to how well the incumbent NPP government was managing the pandemic. The government used the COVID-19 emergency funds to embar on relief programs ostensibly aimed at mitigating the financial and socio-economic effects of the lockdown on a section of the needy populace, as well as small and medium-scale businesses. For instance, the government provided hot meals (Lartey 2020b), absorbed water, and electricity bills for three months (BBC News Pidgin 2020c), and provided a stimulus package for small and medium-scale enterprises (SMEs). The government gained some incumbent advantage as a result, as its campaign messages, and advertising material could refer to the relief effort. There were records of the branding of packed food in the incumbent NPP party colours, aside the campaign message (Myjoyonline 2020c). Many in the electorate could not differentiate between humanitarian aid and political propaganda. The government paid for water and electricity bills for three months (BBC News

Pidgin 2020c) and offered incentive packages for SMEs. Vehicles and other logistics meant for COVID-19 management were deployed by the incumbent government during the election campaigns.

An additional component of incumbent advantage was detected during the voter registration exercise. As a result of the COVID-19, the senior high school final year students were permitted to remain in boarding school accommodations to study for their final exams. The EC in numerous schools set up registration centres to register the students that were qualified to exercise their franchise. By reason of the COVID-19 limitations, other political party activists were not permitted access to the schools but government officials and NPP political activists had access to the students. At such instances, the party officials of the incumbent NPP were able to access the schools and solicited support from first-time voters and warned them that should the NDC win the elections and come to power free Senior High School (SHS) will be abolished (3News 2020; MyNewsGhana 2020). A respondent observed that the COVID-19 infections in Ghana just like most African countries have been limited. Else the indifference to COVID-19 regulations would have colossal damage to the Ghanaian and African people (INT 7, 2021). In essence, health exigencies were thoroughly influenced by political expediency.

3.9 CORRUPTION AND LOST OF TRUST IN THE MANAGEMENT OF COVID-19

The outbreak of COVID-19 pandemic and its management have raised challenges and allegations of corruption across the globe and Ghana was not exempted. As stated in Chapter One, some of the pre-requisites for a successful securitisation (theory) of pandemics are the need for governments and other securitising agents to win and sustain citizens' trust through transparency, accountability, and 'satisfaction' with not only the extraordinary regulations designed to contain contagions but on how the rules are applied and how resources, especially the finances, are used and accounted for. The Transparency International's Advocacy (TIA) and Legal Advice Centres (ALACs) operational in 60 countries received over 1,500 reports of corruption and other irregularities related to the COVID-19 pandemic (ALAC, 2021).

"The cases, from Italy to Venezuela to Ghana, describe bribery, favouritism, and other corruption acts witnessed by citizens in the delivery of humanitarian aid, the enforcement of restrictions on travel and movement, and in the provision of COVID-19 testing and treatment." (ALAC, 2021).

According to Alison Mathews (ALAC Programme Manager), "COVID-19 is not just a health and economic crisis. It is a corruption crisis…And we're seeing it hit those most vulnerable the hardest, including front-line health care workers. Governments are failing their citizens when corruption prevents people from accessing the support and services they need." While pandemic threats necessitate timely national and international mobilisations to prevent, contain, and treat infections, the management of pandemics entail huge financial mobilisation and expenditure, service deliveries, huge procurement of medical and other logistic supplies (Dei, 2021). According to Daniel Eriksson (2021), Managing Director of Transparency International, "The corrupt have seized upon the COVID-19 crisis to line their own pockets at the expense of the everyone else."

In Ghana, mobilisation of funds, procurement of medical and logistic supplies, the delivery of humanitarian aid to the needy, support for distress companies, and the accounting for how internal and international donated COVID-19 funds were spent has prompted untrustworthy discourses. These narratives emphasised a decline in citizens' trust and transparency and hurled civil society discourses into importance. The cancer of corruption is not new to Ghana. Corruption and its pervasiveness impact had been widely prevalent in Ghana. Ghana has strong anti-corruption legal institutions and instruments under the Fourth Republican Constitution. However, lack of public spiritedness, porous and weak institutions, and political expediency buttresses it to thrive. Gargantuan corruption prevails in Ghana and greatly affects socio-economic, political, cultural, and moral developments (Yeboah-Assiamah & Alesu Dordzi, 2016; Kasser-Tee, 2020).

The national resolve to fight corruption, ensure transparency, and accountability in governance made the 1992 create statutory institutions such as the Office of the Attorney General (AG), Auditor General, the Special Prosecutor (SP), Public Accounts Committee of Parliament, for Human Rights and Administrative Justice (CHRAJ), Economic and Organized Crimes Office (EOCO), among others. Undue influence in procurement arrangements and non-compliance with Ghana's procurement rules is one area where Ghana has been cited for corruption (Owusu et al., 2021). Procurements for public health, the COVID-19 since the outbreak, has allegedly, witnessed cases of corruption and scandals amidst irregularities. The Community Development Alliance's Corruption Risk Assessment Report (CDACRAR) reported, among others, that health sector workers were involved in the theft of 36 COVID-19 shield vaccine (each worth US$ 34.9) (Ghana News Agency, 2021, April16; Xinhua, 2021, March 21).

At the height of the pandemic, Vice President on April 13, 2020, commissioned the GH COVID-19 Tracker system, which will help track people with the virus, those who have had contact with others, and improve quarantine reliability. But the corruption risk assessment report declared the US$1 million contract awarded to iQuent Technologies and Ascend Digital Solutions to develop the COVID-19 tracker app raised significant corruption questions. Ascend Digital Solutions was listed a month to the award of the contract in Jersey, a tax haven, and the contract value looked bloated. The amount of GHS1.4 million (US$240,000) spent on launching the tracker was equally outrageous. Contrary to Ghana's procurement requirements, the contracts were awarded to them, when they were not registered with the Ghana Procurement Authorities (GPA).

The Minister for Health bought 300,000 Russian Sputnik V vaccine for US$19 million instead of US$10 million ex-factory price via a middleman Sheik Ahmed Dalmook Al Maktoum of the United Arab Emirates. The clandestine deal was reported by a Norwegian Newspaper, VG. The Minister for Health during questions in the Parliament, claimed Ghana had not paid any monies for the vaccine. But a probe by the Parliament revealed that the MOH had paid monies to the Dubai businessman already without first going through the procurement processes. CSOs and the Ghanaian public called for the resignation or dismissal of the Minister for bypassing parliamentary, cabinet, Public Procurement Authority, and Attorney-General approvals as required by law. The Minister of Health responded that his hands were clean and thatif he was to go down, he would go alone but reveal all the details. The Minister of Health remainedat post.

A 67-page report, 'Strengthening COVID-19 Accountability Mechanisms (SCAM),' revealed several dubious deals the GOG made during the management of the COVID-19 Crisis. The report questioned the contract awarded to Frontiers Healthcare SolutionServices Limited to carry out mandatory COVID-19 antigen tests at the KIA. It argued the contract was awarded to the company without due diligence to Ghana's procurement and contract laws. And that the company was not registered with Public Procurement Authority (PPA) and was not licensed by the health facilities regulator to carry out such a health delivery activity in Ghana prior to the award of the contract.

The tests came at considerable costs of US$150.00 for non-ECOWAS and US$50.00 for

ECOWAS travellers, respectively (SCAM, 2021). The company was reported to have earned US$130 million profit within 18 months, while the Ghana Airport Company made a paltry sum of US$8 million. Many questioned why the lucrative KIA contract was not awarded to NMRI since it led COVID-19 tests at the airports, seaports, and land boarders when the Pandemic broke out. The murkiness of the contract came to lights when the Members of the Vetting Committee in Parliament questioned the Hon. Sarah Adjoa Safo, the former minister for procurement, and Hon. Kwaku Agyeman-Manu, Ministerfor Health February 17, 2021.

The Minister for Health revealed that the contract was awarded on the emergency procurement law subject to the Public Procurement Board of Directors approval in agreement with the Contract Act 663 Section 40 but conceded that the company had no license to function in Ghana at the time. Hon. Sarah Adjoa Safo when questioned on how the contract of the Healthcare Solution Services Limited came about, replied that the Minister of Finance, Hon. Ken Ofori Atta, should be asked (Okudzeto, 2021).

The SCAM report also mentioned the "irregular procurement" award of contract to four Ghanaian clothing business industries. The companies were handpicked without going through the tender and procurement regulations and were given loans of $10m through the Ghana Exim Bank to make PPEs, face masks, medical brushes, hospital dresses and headgear. SCAM labelled the process a clear case of fraud since the companies also were not registered with the PPA at the time of contract award. Similarly, contracts valued GH¢60m for disinfection services and PPE logistics supplied to all districts by the Ministry of Local Government from its allocation under the District Assemblies Common Fund (DACF) for the 2020 Fiscal Year was done without tenders and no accounts rendered. Also, the Administrator of the Common Fund released an amount of GHS166,280.62 to each of the 260districts for the fight against the pandemic. However, no district has accounted for how the money was spent (SCAM, 2021).

Likewise, the supply of 18,000 self-dispensing water buckets; 800,000 pieces of 200-millilitre sanitisers; 36,000 bundles of tissue paper; 36,000 gallons of fluid soap and 7,200 thermometer guns supplied to schools were suspicious deals. The suppliers were not identified, and the costof the procurement were not declared. Hot meals provided for 540,000 2020 West African Secondary School Certificate Examination (WASSCE) and Basic Education Certificate Examination (B.E.C.E) final students and teachers during the final examinations for three weeks was without transparency and accountability. The beneficiaries of the award of contracts, the source of thefund, and their compliance with Ghana's tender laws were not given (SCAM, 2021).

Another issue that has raised several red herrings were remuneration to health and allied workers. In the course of fighting the pandemic mortuary and internment workers, contact tracers, among others either went on strike or laid down their tools for non-payment of salaries and allowances. The SCAM report had raised issues with the sum of US$1.2 million intended for the recompense of 900 contact tracers hired by the GHS to work on case discovery, contact tracking and coverage, 600 of them stopped work due to various grievances, key among them were the inconsistent payment of their daily allowance of US$25 (GHS150.00).

The report claimed, "a corruption risk arises over whether an employment contract regulated the work of the contact tracers, the terms of their engagement, how much was actually paid to them, for how long and why 600 of them dropped out" (SCAM, 2021).
The government's COVID-19 management team allocated an amount of GHS2 million to transport frontline health workers within the Accra metropolis during the partial lockdown. The SCAM report averred that all the amount has not been spent and that GHS1,622,000 remained unaccounted for under the Free Transport for Health Workers allocation. And that it remained unclear how US$7.4 million meant for community consultations and risk transmission from first release of US$35 million from the World Bank was disbursed. A National Information Contact Centre (NICC) at the Accra Digital Centre was established to run information on COVID-19 and its related matters but unclear how much the GoG paid for the setting-up that unit. Again, a sum of US$12.7 million from the World Bank was meant for control, isolation, and treatment. The government disbursed US$2,163 million on 16 hotels and guest

houses throughout the initial upsurge of arrivals. It follows that even if GoG spent an additional US$2 million on all the other quarantine lodges, an amount of US$8.6 million within this allocation remain unaccounted for. Ministers and the Public Health Emergency Operations Centre were to use part of an allocated US$3.4 million to direct and supervise the contracts for private sector management of the yet to be built infectious disease centres and medical villages across Ghana. No work on these centres have commenced yet and yet the money has not been accounted for (SCAM, 2021). This presents an added corruption risk.

But perhaps, the biggest event on spending corruption during the COVID-19 crisis that has raised red flags was the contract given for free food during the limited lockdown in Greater Accra and Greater Kumasi. Many doubted the number of people given he free food, the length of the intercession, and the manner food providers were engaged and the cost of the food. The government has severally given contradictory numbers and amounts. The government claimed GHS42 million was spent free food during the period, but there were no tendering and or accounts (SCAM, 2021).

The COVID-19 Transparency Accountability Project (CTAP), a pan African initiative to ensure transparency and accountability in public expenditure, reported the lack of clarity, and delay in accounting and auditing, among others, of COVID-19 funds and expenditures. (Myjoyonline, January28, 2021; Myjoyonline, April 16, 2021; Myjoyonline, April 22, 2021; Myjoyonline, July 9, 2021; Myjoyonline, June12, 2021). The sceptre of corruption was also emphasised by the Community Development Alliance (CDA) and the Commonwealth Foundation report entitled, Strengthening COVID-19 Accountability Mechanisms (SCAM) (Ghanaweb, 2021, May 12). The World Bank country representative had to come out and state that the World Bank had donated $430 million dollars to Ghana rather than $130 million cited in some government books. The Ghana Anti-Corruption Coalition (GACC) in alliance with Economic Governance Platform (EGP) and some Civil Society Organisations (CSOs) have called on the government, as a matter of urgency, account for how COVID-19 funds were spent. Ghana's Parliament had tabled the motion for a forensic audit of COVID-19 funds but the incumbent government, through the Deputy Speaker of Parliament, has shot it down.

3.10 CONCLUSION

Developing countries, especially African states with deep structural weaknesses are chiefly vulnerable to infectious diseases such as the pandemic influenza because of their weak health infrastructure and weak resources. It has been demonstrated above that apart from scientific and other forms of health prerequisites for managing pandemics, socio-cultural and political culture exigencies of African societies should be included in the pandemic management calculations.

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CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

4.0 SUMMARY OF FINDINGS

The main objective of the study was to analyse the politics of managing epidemics as global security threats with Ghana as the case in point. It found:

Securitising the pandemic:

- That Ghana as a member of the WHO fulfilled its obligations under IHR 2005 after WHO declared COVID-19 as PHEIC on January 30, 2020, and a pandemic on March 11, 2020. After Ghana verification of its first two cases of COVID-19 on March 12, 2020, on March 15, 2020, the President of Ghana asked the Minister for Justice and the Attorney-General to quickly tender to Parliament an emergency legislation in accord with Article 21(4) (c), (d) & (e) of the 1992 Constitution of Ghana. COVID-19 was declared a PHEIC inaccordance with Section 169 of the Public Health Act, 2012 (Act 851).
- That the Imposition of Restrictions Bill, 2020 (Imposition Bill) approved by Parliament and endorsed by the President under a certificate of emergency on March 22, 2020, the Imposition of Restrictions Act, 2020 (Act 1012) was in accordance with the Emergency Powers Act 1994 (Act 472) is the main law of general claim to managing state of emergency. The Imposition of Restrictions Instrument, 2020, restricted social liberties and imposed heightened health etiquette, and sanctions in breach of compliance with the stipulations of Executive Instrument 64 of 2020, started with a speech act.

The Clinical Management of the Disease

- That Ghana has since the deportation of Ghanaians from Nigeria in the early 1980s has established NADMO to manage crisis. In the light of today's transitional security threats including and epidemics/pandemics, the GAFCSC, GIMPA, LECIAD of University of Ghana have organised training and capacity building and prepared the security agencies, health professionals, journalists, and transport unions, among others, for emergency crisis management.
- That during the 2013 Ebola Outbreak in West Africa, the UN and WHO's use of Ghana'scapital Accra as its headquarters for the training and use of several Ghanaian health workers in containing the Ebola pandemic better prepared them on how to respond to COVID-19.
- That groundworks were initially health sector motivated and involved infrastructure, equipment, logistics, human resource capacity building and improvement, public education and awareness creation, community, and related sectors arrangements. It also entailed sensitisation, collaboration, and solicitation of media support, and press releases furnishing updates and information to the public.
- That the NMIMR and KCCR were the only institutions that could test for and verify the COVID-19.
- That due to the increasing cases of COVID-19, and the need for a lager testing, other facilities within and outside the health sector were built, refurbished, evaluated, and ascribed to provide testing for COVID-19, raising the number of laboratories capable of PCR testing for COVID-19 from 2 to 16 by April 2020.
- That, despite the numerous valuable activities undertaken as part of the health sector preparation and answer to the COVID-19 contagion in Ghana, various shortcomings were acknowledged such as erratic scarcities of PPEs, geographical limits in testing for COVID-19, tardy COVID-19 tests receipt, inadequate staff, and shortage of COVID-19 laboratory reagents.

- That despite the availability of a credible framework to handle the pandemic, resources, funds, and logistics were not readily available, there was therefore the pressure to acquire funds and the necessary logistics, expand facility capacities and develop and adapt human resources abilities.
- That Ghana has been given 13. 8 million doses of vaccines. 4.87 million Ghanaians are fully vaccinated constituting 15.7 percent of Ghana's population. Ghana had aimed to vaccinate 20 million of its 32 million resident population by the close of October 2021.
- That Ghana's management of the COVID-19 pandemic based on symptoms identification, quarantine, contact tracing and tracking, and treatment has been criticised as a curative approach than a preventive approach to managing pandemic influenzas.

Misperceptions Engendered During the COVID-19 Management

- That misconception and misperception (such as blacks are immune to the pandemic, the tropical weather prevents the contagion transmission, only elderly people with already existing health conditions are vulnerable to the pandemic, Akpeteshie and neem tree leaves are panaceas to the pandemic and vaccines are to reduce black population) emerged on social media that aided misinformation on vaccines, the high vaccine hesitancy, low vaccine acceptance, and non-adherence to COVID-19 restrictions.

Partnerships and Collaboration

- That the private sector, NGOs, Political Parties, the World Bank, IMF, the EU, US, Germany, France, the UK, among others, made both monetary, vaccine, and other COVID-19 logistics contribution to Ghana.

The politics and discourse of managing COVID

- That the bifurcation Ghana's Fourth Republic political scene and domination by the NDC and NPP created hyper-competitive environment that had many posers for the management of COVID-19 in Ghana.

- That the 2020 Elections, the issuance of the Ghana Card, and the compilation of a new voters' register had veritable impact on Ghana's COVID-19's management that cannot be overstated as political expediency triumphed over adherence to COVID-19 restrictions.
- That electoral campaigns during the 2020 Elections did not revolve around how the economy performed and whether the incumbent government had delivered on its promises as used to be the case in the past. In 2020, the political advertising and campaign message shifted on how well the government was managing the pandemic.
- That the COVID-19 resources provided the incumbent advantages as its campaign messages and advertisement material were referred as reliefs and there were scores of reports of packed food branded in the party colours of the incumbent.
- That due to COVID-19, senior high school students in their final year level were kept in boarding schools allegedly to prepare for their final examinations. The EC opened registration centres in the schools, registered the students that were qualified to vote, and granted the incumbent and its supporters to access to the students who were denied other political parties.

Corruption and Lost of Trust in the Management of COVID-19

- That the COVID-19 pandemic outbreak and its management have raised challenges and allegations of corruption. The containment and management of the pandemic entailed huge financial mobilisation and expenditure, service deliveries, procurement of medical and other logistic supplies. The corrupt have taken advantage of the COVID-19 crisis to enrich themselves at the expense of the general public.
- That contracts were awarded without following Ghana's contract and procurement laws, cost of contracts was bloated, contracts were awarded them, when they were not registered with the Ghana Procurement Authorities (GPA), huge sums of funds were not accounted for, unused funds were not returned to government covers, beneficiaries of contracts, and the source of the fund were not stated.
- That healthcare and allied workers were not regularly paid their contract remuneration that resulted in strike action and laying down of tools; and

- That the procurement of medical and logistic supplies, the delivery of humanitarian aid, support for distress companies, and the accounting and management of COVID-19 funds have all affected citizens' trust and approval.

4.2 CONCLUSIONS

The study based upon the findings concludes

- That West African states such as Ghana are vulnerable to infectious diseases such as the pandemic influenza because of their weak health infrastructure and weak resources; and
- That apart from scientific and other forms of health prerequisites, the management of pandemics was hindered by the various factors that affected the African societies, such as the political culture and socio-economic conditions

4.3 RECOMMENDATIONS

- That the preventive measures such as reliable sources of portable water, cleanliness, places of convenience, good housing outlays, and heightened hygiene etiquette shouldbe made a permanent culture of society and not only when epidemics and pandemics break out.
- That African states should restructure the expenditures to allocate larger portion of their budgets for improving upon their health infrastructure, healthcare human resources and logistics to better contain epidemics and pandemics. This is important because West African states cannot always count on the international community to come to their aid during pandemic emergencies.
- Misperceptions, culture, and superstition seriously work against efficient health management in epidemic and pandemic crisis management. It is therefore very important for states to design communication mechanisms to counteract such misinterpretations. Such measures will be most effective if there exists trust, transparency, and accountability in governance.
- There is the need to fight corruption, which has assumed impunity dimensions. This can be done by strengthening the institutions meant to fight corruption, decentralising and devolving power and authority to the districts and municipalities with a strong

oversight responsibility placed in the hands of CSOs.

- That, finally, the international community should demand greater accountability, and transparency after donating funds to West African states. this can be done through exercising greater surveillance how the donated funds are used.

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