

## Conflict Research Programme

### Research Memo

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# Governance Implications of Epidemic Disease in Africa: Updating the Agenda for COVID-19

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African countries have much experience with epidemics of communicable diseases. Nonetheless, certain aspects of the COVID-19 pandemic are new; for example its impacts on the global economy, and the extreme restrictions on social interaction that are recommended as mitigation measures. Other aspects of the pandemic are familiar; for example high levels of illness that overwhelm limited health care capacity, a spike in mortality, and the conjuncture of these two elements with a severe economic downturn.

This memo summarises some of what is known about epidemic disease and governance in Africa based on past experience, and poses questions concerning COVID-19. The principal research resources include the [Commission on HIV/AIDS and Governance in Africa](#) and the [HIV/AIDS, Security and Governance Initiative](#). In this respect it supplements recent surveys on the issue by [Crisis Group](#) and the [Carnegie Endowment](#). There have also been extremely alarmist predictions such as that [reported from the Quai d'Orsay](#), that the epidemic will cause African states to collapse, necessitating international interventions. This is not an evidence-based claim.

The memo then briefly examines: (a) impacts of epidemic disease on state capacity; (b) impacts on social and economic distress (especially food insecurity); then turns to (c) vicious cycles of interaction between disease, conflict and state failure; and (d) the implications of government responses to epidemics.

The memo poses questions that should be examined in order to ascertain the probable governance implications of COVID-19 and identifies research gaps.

## Recent Research on Epidemics and Governance in Africa

There is a [rich historical literature on epidemics and their impacts](#) during Africa's imperial encounter and on [infectious disease control and colonial policy](#). The devastating human and livestock diseases that arrived with colonialism, along with the famines and disruptions of that era, contributed to an [irruption of millennial cults](#). Of more immediate relevance is recent research on the governance impacts of HIV/AIDS and Ebola. Both those diseases caused higher mortality than COVID-19: in the case of AIDS, spread out over many countries and many years; in the case of Ebola, concentrated in a few countries in a short period of time. Both caused immense economic and social strains. It is instructive that neither HIV/AIDS nor Ebola caused a breakdown in governance leading to social chaos, nor wider security crises.

The principal governance and security impacts of these epidemics occurred through secondary effects such as high food prices and through government policies that were seen to be arbitrary, unfair or cruel. These were among the findings of the [UNECA's Commission on HIV/AIDS and Governance in Africa \(CHGA\)](#) (2008) and the [HIV/AIDS, Conflict and Security Initiative \(ASCI\)](#) (2009), both of which I set up and helped run.

The stimulus for these collaborative research exercises was a forecast that Africa's governance progress was being sent into reverse by the way in which AIDS targeted productive adults and threatened to hollow out institutions: I called it [state-building in reverse gear](#). Others went much further and projected dystopian fantasies of Africa as [an anarchic wasteland](#); of law and order evaporating as soldiers and policemen die in droves; with feral bands of [unsocialised children turning to crime](#), [soldiering](#) or [terrorism](#); of services collapsing due to disease and hunger. Many Africans suspected that the state failure framing was driven by a western interventionist agenda.

[The 2000 U.S. National Intelligence Estimate](#) forecast a vicious interaction between a high disease burden, especially HIV/AIDS, and state failure and armed conflict. The assumptions underlying this prediction were: (a) that military capacities would be reduced, leaving countries vulnerable; (b) that economic crisis and reduced state capacity would increase conflict over scarce resources; and (c) that there would be a vicious spiral with conflict and disease worsening one another.

As it transpired, nowhere in Africa did citizens become revolutionaries and turn against governments that had purportedly lost legitimacy through failing to stop disease. The most militant health activism in Africa—South Africa's Treatment Action Campaign—did not seek to bring down the African National Congress, but rather [to change its policies on HIV/AIDS](#).

When it became clear that the most disastrous societal and governance outcomes were not going to occur, I tried to explain why, in a paper that [synthesised the evidence from the global story](#) and in a short book that focused on the question of [why HIV and AIDS in Africa had coincided with an expansion of inclusive forms of governance](#). This cautionary tale should give us reason to be skeptical about some of the more extreme forecasts of the impacts of COVID-19 in Africa. It is unlikely that the epidemic will destroy social order or state authority. The global economic recession may, however, cause the most severe economic downturn in Africa for thirty years, which is cause for very serious concern.

In exploring the implications of COVID-19, we need to be alert to what is similar to these recent experiences, and what is different, due either to the nature of the disease, or the different global conditions in which the pandemic is occurring.

### State Capacity

**Overwhelmed health services.** African countries already have weak health systems, especially hospital care. While the U.S. is struggling with 170,000 ventilators (one for every 500 people), [the 41 least-resourced African countries have just 2,000 between them](#) for a larger population. [Uganda has just 55 intensive care unit beds](#) (one for every 750,000 people) and Nigeria has

only one for every 1.25 million people. Some African countries have none. Health facilities are overburdened with endemic diseases such as malaria and TB and stressed by a caseload of people living with HIV. There is a host of undiagnosed illness, for example diabetes and hypertension. Africa faces other simultaneous epidemics such as measles. It is clear that COVID-19 completely overwhelms existing capacities, both for direct morbidity but also because of the increased co-morbidity that is likely (in this case TB and AIDS). Therefore, COVID-19 demands emergency responses outside the regular health service.

In the early 2000s, research into the [human resources in the health sector](#) had two key findings with respect to Africa: (a) that the great majority of health care providers were informal and community health workers, and (b) that there was a vast shortage of health workers, exacerbated by austerity measures. In 2005, the WHO recognised the need to urgently fill a gap of approximately 1 million health workers in Africa and upgrade the skills of the existing, overstretched workforce.

Over the last fifteen years, there has been a substantial increase in African state health capacity, partly in recognition of these findings, and partly because of internationally-funded programmes targeted at individual diseases such as malaria, TB and HIV/AIDS. There has also been a vast expansion of private health care provision for the emerging middle class. The outcome has been that Africa's health systems are stronger than before. However, the fundamental situation is unchanged: public health services are *already* in permanent crisis, so that epidemic response requires emergency responses. Increasing urbanisation and rising incomes have also changed patterns of health care uptake.

One of the key findings of the [Sustainable Livelihoods Research Consortium](#) was that [government legitimacy derived less from the standard and capacity of services delivered than the extent of consultation in designing and implementing them](#). However, it is possible that in urban areas, people's expectations of public health care may have risen, so that failures to deliver will undermine state legitimacy.

**Human resource losses.** In the early years of HIV and AIDS in Africa, there were many AIDS-related deaths among government ministers, senior officials in government, army officers and businessmen. This led to a fear that governing institutions would be 'hollowed out', losing their most experienced and capable individuals, and would therefore become dysfunctional. Indeed, losses in some sectors were devastating, and in patrimonial systems of rule, the loss of a single key individual can lead to a crisis. But institutions *per se* weathered these losses and continued functioning.

Current projections for COVID-19 mortality do not suggest massive losses comparable to prior epidemics. However, the fact that highly-mobile older men are a very vulnerable category implies that it may replicate HIV/AIDS and disproportionately affect people in leadership positions. The implications of this need further study.

**Military capacities.** In the early 2000s there was widespread alarm that armies would be decimated by HIV and AIDS, however [they proved remarkably robust](#). Infantry-based forces are designed to be able to continue functioning despite suffering casualties and amid disruptions. The stresses armies face on account of epidemic disease may be comparable to those of wartime (a comparison that is often made), but withstanding such stress is part of the job description of officers and the overall design of the institutions. Among the design features are human resource and institutional redundancy: individuals can be promoted instantly to fill gaps and every key function can be undertaken by several different parts of the overall institution.

**Policing.** Much less research has been conducted on police services and the dual stresses posed by epidemic disease, namely (a) human resource losses combined with (b) increased social disruption placing additional demands on policing. The experience of HIV/AIDS suggests that [policing is a crucial area needing examination](#). A particular set of concerns in the case of HIV/AIDS was that the police are the frontline interaction between the authorities and those most affected by the epidemic, as much HIV transmission is associated with groups

and activities that are at the margins of the law, or illegal, including commercial sex and intravenous drug use. Similarly with Ebola, police practices and attitudes in enforcing quarantine and isolation were crucially important to the trajectory of the epidemic. In the case of COVID-19, the police have been instructed to implement unpopular control policies, and their practices in doing so will be crucial in determining whether these policies are implemented in a fair, sensitive and consensual manner—or not. Policing is not undertaken only by the police but also by informal enforcement mechanisms and in some places by paramilitaries or the army. In the U.S. and internationally, [local gaols have been identified as hot spots for transmission](#) and prisons are places of high risk.

There is a pressing need for basic information and research into police forces, detention facilities and COVID-19 in Africa.

## **Socio-economic Distress**

***Distress and social crisis due to emergency health spending.*** In Africa, most spending on health care and support for the sick comes from family budgets, and most care for the sick is by female family members. This causes impoverishment, withdrawal of children from school, and occasionally household breakdown. However, there is little indication that this distress and disruption will contribute to short-term social unrest. What warrants examination is the longer term implications of household impoverishment and lower educational achievement, especially for girls.

***Orphans and social casualties.*** AIDS caused a huge increase in the number of orphans and children living in poverty. This did not, however, lead to feared levels of social disruption. [African societies \(social and family networks\) cope with large numbers of orphaned children due to HIV/AIDS](#) and armed conflict. The most effective mechanisms for preventing social distress are supporting community organisations and networks. COVID-19 is not expected to increase the number of orphans.

***Livelihoods and employment.*** Among the adverse implications, to be investigated, are the following:

- Widespread unemployment due to the disruption of commodity exports, the collapse of the travel and tourism sectors, and a sharp decline in trade and marketing.
- Loss of income to small producers who cannot bring their products to market.
- Crisis in the domestic service sector associated with lockdown policies and wider economic downturn.
- [Decline in remittances](#) from relatives in Europe, the Middle East and North America, especially from those working in hard-hit sectors such as taxi drivers, restaurant and hospitality sector workers, and the informal sector.
- [Disruptions in accessing social networks](#), which the poorest rely upon for assistance.

***Food insecurity.*** Epidemic disease has the potential to have serious negative impacts both on supply and demand. Food production, transport and marketing can be affected leading to food price increases and (in some places) absolute shortages; unemployment and impoverishment can lead to a decline or collapse in real economic demand among the poor. This 'scissors' effect can potentially lead to famine.

In the case of HIV and AIDS, Alan Whiteside and I wrote about the prospect of '[new variant famine](#)', consisting in poor, HIV/AIDS-affected households dropping into destitution and starvation on account of the combined effects of the epidemic and the southern African drought of 2002-03. Fortunately that didn't occur as feared: [there was widespread misery and hunger but no famine as such](#). The disease did not cause a major disruption in food supply or marketing, and the societal distress was sufficiently slow-paced and dispersed that visible famine did not develop.

The COVID-19 pandemic is potentially much more serious for food insecurity. The demand-side disruptions have been summarised under 'Livelihoods and employment,' above. Potential supply-side disruptions that need investigation include:

- How it intersects with other major stressors, such as the east African locust infestation, the continuing economic crisis in Sudan, and mass displacement and other vulnerabilities elsewhere.
- The extent and nature of food imports disruption and the potential for food price increases.
- The nature of local marketing disruption due to COVID-19 control measures.

**Social unrest.** It is very rare that epidemic disease *directly* causes political crisis. Unrest is refracted through secondary effects, such as unpopular epidemic control policies (see below), unemployment and food insecurity. High food prices, often seen as an abrogation of a government's contract with the urban poor, [are a common spark for riots](#). For many poor people, the lottery of infection is less real than the certainty of hunger, the rationale for repressive measures is unclear at best, and they see officials taking advantage of emergency powers for personal or political gain. People mobilise against the injustices, real or perceived, of the control policies. Little is known about popular perceptions of COVID-19 and the policies initiated in response, on which to make reliable forecasts: surveys such as the Afrobarometer will doubtless be providing these data shortly.

## Vicious Cycles of Conflict, State Failure and Disease

**Governance crisis.** The economic crisis associated with COVID-19 has the potential to cause governance crises. The drop in oil prices, caused in part by the pandemic, will cause a collapse in revenue among Africa's oil producers. For some of them, an oil price of \$30/barrel does not cover production costs so their revenues may fall to zero. Countries dependent on commodity exports and tourism will also face huge revenue losses. As currencies depreciate, debt servicing payments denominated in US dollars become even less affordable. These economic pressures not only cause distress and potential social unrest, but also squeeze the political budgets on which rulers rely to secure their political support. This can spell political crisis, especially in countries facing elections. Non-state actors including rebel groups and criminal gangs can step into fill gaps in services and public authority. Analysis of these dynamics is needed.

**Armed conflict.** Epidemic disease has rarely if ever been the direct cause of war. On occasions it has determined the outcome of a conflict (most notoriously the Spanish conquest of Mexico). Massive demographic ruptures caused by epidemics and famines may also have contributed to political instability (e.g. in large swathes of Africa in the late 19<sup>th</sup> century). COVID-19 does not threaten demographic rupture on that scale.

War is undoubtedly bad for health, but its impacts are uneven and specific to circumstance and pathogen. Armed conflict undermines health services and food security, and trapped-in-place (e.g. besieged), displaced and refugee populations can be vulnerable to health crises including infectious diseases outbreaks. [Child mortality tends to go up during armed conflict](#) and stay high for some time afterwards. But the relationships are complicated and the correlations uneven: for example, conflict-affected populations may be relatively isolated and immobile, and [thereby ironically relatively protected](#) from some infectious diseases. Much has been learned about [controlling communicable diseases in camps for refugees and IDPs](#) and such settings often have public health expertise and infrastructure that can allow for effective outbreak response. The greater risks of communicable diseases may come at war's end, as transport routes open up and displaced people return home. Cantonment sites where combatants congregate for disarmament and demobilization are also a potential site of contagion, making DDR initiatives problematic. All these issues require research.

**The global context.** Recent pandemics unfolded during a period when international institutions and U.S. policies were aligned to support evidence-based multilateral solutions. By contrast,



COVID-19 is the first pandemic under the current world order dominated by zero-sum transactional politics.

The United Nations, both through the Security Council and through its specialised agencies, took a lead in organising the international response to HIV/AIDS and Ebola. There were UN Security Council resolutions on both; HIV/AIDS had its own UN agency and Ebola had its own emergency mission. In 2003, United Nations Secretary General Kofi Annan spoke of the '[triple threat](#)' posed by weak governance, food insecurity and epidemic disease in Africa. He was particularly energised by the combination of drought and HIV/AIDS in southern Africa. The United Nations organised a system-wide response and designated the [director of the World Food Programme to be special envoy](#) for this threat in southern Africa.

While the U.S. tended to operate in parallel to the UN, sometimes with insufficient coordination, it shared the same analysis of the problems posed by epidemic disease. For example, in the final month of the George W. Bush administration, the 2008 U.S. National Intelligence Council released a special report, '[Strategic Implications of Global Health](#)', which concluded that U.S. international health initiatives were successful, not only in tackling infectious diseases such as HIV and AIDS, but also in advancing U.S. influence around the world. The report's concluding section, 'Health as Opportunity: A New Look at a Successful Paradigm,' argued for an expansion of American medical diplomacy.

This situation no longer exists. The UN Security Council has not succeeded in taking a position on COVID-19. The UN organisation is weak. The current U.S. administration is actively undermining the WHO and is scornful of China's use of medical diplomacy.

## **Epidemic Response Policies**

State policies in response to epidemic disease commonly have greater governance impacts than the diseases themselves. All of the following are issues demanding more information and research.

**Resistance and distrust.** These are common during epidemics, and their most common cause is the authorities' enactment of unpopular control policies. Colonial governments' policies of enforcing quarantine (to control cholera or relapsing fever) or population relocation (e.g. away from tsetse-infested areas) were deeply resented, as were the medical screenings imposed by South Africa's mining companies on migrant labourers. In 2014, the Liberian government's attempts to lock down townships in the capital Monrovia caused fierce resistance, compelling it to change policy. Other cases of resistance and distrust include attacks on polio vaccination teams, [driven by fears](#) that the teams were spies or were implementing secret policies aimed at sterilising women.

**Abusing emergency powers.** Governments assume far-reaching powers in health emergencies—and indeed are entitled to do so under the exemptions provided by the [International Convention on Civil and Political Rights, Article 22.2](#). When police and officialdom are permitted to stop and search people, confine them in place or forcibly relocate them, confiscate and destroy dwellings or vehicles, or hold commercial cargo and passengers in detention, they obtain vast opportunities for abuse.

**Repurposing emergency powers.** Governments can use health-related emergency powers for all kinds of other agendas of social and political control, from prohibiting rallies and tracking dissidents to expelling entire communities and cancelling elections. A state of emergency is also an opportunity for arbitrary measures without reference to law.

**Perceived inequity in provision of medical services, welfare and economic assistance.** This is self-evident: complaints about unfairness can easily translate into ethnic or other grievances.

**Petty corruption and smuggling.** Every restriction on movement or economic activity creates a market for those who can find a way around official controls, through bribery, smuggling or other activities. Lockdown is likely to provide more opportunity and income to those already engaged in illegal activities of this nature.

**Evasion of official control and reckless behaviour.** In every past epidemic, poor people have managed to evade official control measures, behaving in ways that health professionals regard as recklessly exposing them to infection. The rationale for poor people's behaviour is that they need to earn a daily income, so they would rather take their chances with the lottery of infection than surrender to the certainty of hunger.

**Inappropriate transition out of control policies.** In East Asia, Europe and North America, [lockdown policies are designed with one of three exit strategies in mind](#): 'hold' which consists of reducing transmission to near zero; 'build' which is buying time to build up hospital capacity to cope with a second wave of infections; and 'shield' which is developing methods for protecting vulnerable populations from infection when restrictions are lifted. African countries may not have determined which exit strategies are best, how to implement them, and the implications of success or failure in their exit plans.

**Recovery benefitting elites and corporations.** It is common for disasters and disaster response to strengthen elites relative to ordinary citizens and to advantage corporations over small producers. This is more relevant to the socio-economic dimensions of epidemics than it is to the health sector itself. For example, emergency bailouts to businesses benefit larger businesses rather than smaller ones; and the disruptions in small businesses' cashflow and small producers' supply chains may cause a wave of bankruptcies, creating market opportunities for corporations. In the case of COVID-19, the disruption to face-to-face meetings and [the shift to the dominant use of remote technologies](#) for management may also have important consequences for social power.

**Political-economic system change as a consequence of economic crisis.** In my book, [The Real Politics of the Horn of Africa](#), I argued (following Bob Bates' [When Things Fell Apart](#)) that the severe economic crisis of the 1980s caused a fundamental reconfiguration of African political economies: states no longer possessed the resources required for sustaining basic governance functions, including security. The transactional politics of regime survival supplanted the institutional logic of state-building; the informal sector grew to surpass the formal sector—indeed one of the goals of structural adjustment was to incentivise entrepreneurship. As economies recovered, the logic of the political marketplace remained dominant.

Political marketplace regimes are vulnerable in case of major contractions in supplies of political finance, for example if their revenues from oil collapse. Such stresses could imperil the stability of rentier-patronage regimes based on oil or other commodity exports.

The current situation threatens Africa's first widespread economic recession for thirty years. Generally speaking, African economies—both formal and informal sectors—have been growing for three decades, and weathered the 2008 global recession remarkably well.

What is distinct about the looming recession is not only its scale but the fact that it impacts both the formal and informal sectors. While the global recession primarily impacts the formal sector plus remittances, the lockdown policies are also squeezing the informal sector. Deep and protracted austerity could, in principle and in some places, herald a return to some of the pathologies of the 1980s and 1990s, such as subcontracted security regimes financed by the proceeds of war economies. Economic recession may discredit monetised patronage regimes

but not necessarily challenge their survival. The political marketplace as a broader system emerged precisely from these types of crisis and it is more likely to become more entrenched, albeit reconfigured, as a consequence.

By contrast, institutionalised systems and emerging democracies are more endangered by economic crises of this magnitude. State finances are simply unable to deliver on the kinds of welfare and development that lie at the heart of functional democratic politics.

## **Questions to Pose Regarding the COVID-19 Pandemic**

The governance implications of the COVID-19 pandemic for Africa depend on how the pandemic develops in Africa, on the nature of governance systems, on secondary impacts and post-pandemic exit strategies and recovery plans, and on the international context and response.

**Africa's COVID-19 epidemics.** Africa's COVID-19 crisis should be seen, not as a generalised pandemic but as different national and subnational epidemics that will play out differently depending on demographic and social factors, which is why [knowing the national epidemic](#) is so important. At present, far too little is known about key factors that will determine the epidemic's trajectory in Africa, including how COVID-19 intersects with malnutrition and with other disease burdens such as malaria, TB and HIV, and transmission patterns in Africa's demographics.

**Africa's governance systems.** The pandemic's impact is a factor compounding the existing stresses on Africa's governing institutions. It is unlikely that the illness and death caused by COVID-19 will in themselves be a cause for governance disruption or state crisis. More concerning is that the *fear* of social breakdown or governance collapse will cause governments to enact repressive measures aimed at regime survival. The economic recession, fiscal crises and especially the squeeze on regime political funding are likely to intensify transactional survival politics at the expense of public goods.

Special attention should be focused on police services, including how they are impacted and how they respond.

The use of emergency measures and restrictions also demands examination: what are the motivations for these? On what evidence are they being implemented? What other purposes do they serve? How are people responding to them?

**Secondary impacts.** The repercussions of the COVID-19 pandemic on poverty, employment and food security are matters requiring urgent attention. These issues will become particularly salient during the recovery phase when major assistance packages are targeted and new business opportunities arise.

**International context.** The comparison between the vigorous international leadership in response to recent epidemics and the weakness of today's multilateral leadership is striking. Africa is the continent most reliant on multilateral organisations and the principles of international cooperation and the rule of law. The current context is therefore discouraging.





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