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KNOWLEDGE PLATFORM ON INCLUSIVE DEVELOPMENT POLICIES

COVID-19 IN AFRICA

A SYNTHESIS OF 12 COUNTRY STUDIES

DZODZI TSIKATA & GERTRUDE DZIFA TORVIKEY

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COVID-19 and Africa: A Synthesis of 12 Country Studies

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Acronyms

AAS- African Academy of Sciences
AfDB-African Development Bank
Africa Centre for Disease Control (CDC)
African Continental Free Trade Area (ACFTA)
AMSP-Africa Medical Supply Platform
ARUA- African Universities Alliance
ATM-Automated Teller Machines
AU-African Union
AVATT-Vaccine Acquisition Task Team
AVS-Africa Vaccine Strategy
BOLSA- Bureaus of Labour and Social Affairs
CONCVACT-Consortium for COVID-19 Vaccine Clinical Trial
CSOs- Civil Society Organisations
COVAX- Vaccines Global Access
CVO-COVID Organics
End-SARS-End Special Anti-Robbery Squad
GDP- Gross Domestic Product
GMA-Ghana Medical Association
HIV-AIDS- Human Immunodeficiency Virus- acquired immunodeficiency syndrome
ICT-Information Communication Technology
ILO-International Labour Organisation
IMF-International Monetary Fund
INSTAT- Institut Nationale de la Statistique
LDC-Least Developed Country
NLPS- National Longitudinal Phone Survey
PPE- Personal Protective Equipment
RDT- Rapid Diagnostic Test
STEM- Science, Technology, Engineering, and Mathematics
UN- United Nations
UNECA- United Nations Economic Commission for Africa
UNESCO-United Nations Educational, Scientific and Cultural Organization
WHO-World Health Organisation
WFP-World Food Programme

EXECUTIVE SUMMARY

Concerned with the implications of COVID-19 for inequalities in Africa, the INCLUDE Platform put out a call for country studies on Africa's experience of the first wave of COVID-19 (March to December 2021). The call was for studies focused on a critical examination of containment and mitigation responses to the pandemic and their impacts in African countries, with special reference to marginalised, vulnerable and disadvantaged social groups. This report synthesises the findings from research conducted in the 12 countries selected for the study. The countries- Benin, Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Mozambique, Niger, Nigeria, Rwanda, Uganda, and Tunisia are spread across Africa and have interesting similarities and differences.

Socioeconomic and Political Contexts

Eight (8) of the study countries (Benin, Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, and Uganda) are both low income and LDCs, while the other four (Ghana, Kenya, Nigeria, and Tunisia) are lower middle income. Another common feature of several countries is the fact that their services sectors contribute the largest share (between 30 to 53%) of their GDP (Ghana, Kenya, Ethiopia, Nigeria, Rwanda, Tunisia, and Uganda). Even when it is not the most dominant, services are important for countries such as Mali and Niger. This is a matter of concern because the services sectors in Africa are dominated by small precarious enterprises, which except for ICTs, were very badly hit by the pandemic. All the study countries were identified as multi-party constitutional democracies. However, for many of the study countries, there were significant political stressors, including Islamic insurgencies of different degrees of severity, threats of civil war and political instability, compounded in some cases by the postponement of elections, longstanding political crises and coups d'état, the generalised breakdown of security, police/armed forces brutality and mistrust of government, terror attacks and police brutality, closed political systems, elections related political tensions, and distrust for government. The studies found that features of these contexts were implicated in COVID-19 effects and responses.

COVID-19 Experiences and Impacts

There has been broad generic uniformity in Africa's COVID 19 experiences- low infection and mortality rates, low levels of hospitalisations; common responses in terms of containment and support measures and massive economy wide disruptions because of the widespread informality of work, border closures and poor social policy. The country studies identified two kinds of impacts - a) infection and mortality rates and b) socio-economic and political impacts. Question marks about Africa's infection and mortality statistics notwithstanding, there is evidence to suggest that infections and related mortality numbers have been relatively low, although rising significantly with the second and third waves of the pandemic. Given the low rates of vaccination (7.35 % of Africa's population by 13/12/2021[3]) and the crisis of the COVAX facility, there is cause for worry.

The impacts of COVID-19 on access to health in countries in SSA has not been as devastating as earlier predicted based on expected infection rates and the major deficits in health facilities and problematic doctor and nurse patient ratios in all the study countries. However, data from other surveys showed that most respondents reported that they were able to access health care, and those who could not, cited lack of money or transportation challenges rather than reduced access due to covid-19 infections.

[3] https://africacdc.org/covid-19-vaccination/

Much more troubling for Africa have been the socio-economic impacts of COVID-19, such as economic contraction, livelihood disruption, food insecurity and growing inequality. The African Development Bank (2021) described the levels of contraction of economies in Africa as a recession, the severest witnessed in half a century. In general, African economies contracted by 2.1%, with tourism, oil, and other natural resource extraction the hardest hit. Annual GDP growth declined sharply from impressive 2019 figures for many countries. The contraction of economies has translated into significantly negative effects on livelihoods, food security, education, and health in various study countries. Studies found that the effects of the pandemic differed significantly by location, and urban areas were the most affected by declining unemployment and livelihood disruptions. In terms of gender, more women in urban areas lost jobs and suffered other disruptions to their livelihoods than men. Disruptions in the economy also affected household businesses. A third of households in Kenya, Nigeria, and Ethiopia shutdown businesses at the initial stages of the pandemic and revenues from family enterprises fell by over 70% in Uganda and Mali (Paci, 2021). Massive job losses and decline in incomes have been recorded in the case study countries. At household levels, labour income losses were ubiquitous.

The COVID-19 pandemic has exacerbated pre-existing conditions of household inequality particularly in incomes and earnings, access to food, water, hygiene, sanitation infrastructure and electricity. This has created additional vulnerabilities to the poor. These inequalities in access to basic needs has meant that the poor bear the heaviest burden of the COVID-19 pandemic containment measures. Africa's urban populations, mostly live-in informal housing structures without health, sanitation, and other vital amenities.

Children's education has also been affected although virtual learning programmes were implemented in many countries. The level of uptake in online lessons varied from country to country. School closures have also affected children who depended on school feeding programmes. With the shifting of the state's social responsibility to households, women must shoulder the burden of care.

Covid-19 Containment and Mitigation Measures and Impacts

Similar containment measures- social distancing, frequent hand washing and use of hand sanitizer, PPEs, lockdowns, school closures and border closures have been used across Africa and in the study countries. Similarly, common mitigation and support measures have been directed at households (i. access to basic services- water, electricity, and health; ii. social safety nets- cash transfers, food distribution and price controls, and prisoner releases; and iii. income protection- income and consumption tax reductions/suspensions. For businesses, support has consisted of low interest loans, relaxation of loan repayment requirements and tax benefits.
The appearance of uniformity notwithstanding, the portfolios of country responses have differed in intensity, spread and beneficiaries. For example, the beneficiaries of cash transfers have included different combinations of the following categories of persons identified as vulnerable or facing existential crises: poor women, people with chronic and degenerative diseases; children in difficulty, people living with disability, pregnant women without a source of income, women headed households, women with six or more dependents, families.

Mitigation and stimulus measures, though welcomed by citizens, have been mainly short-term, poorly targeted and implemented, and biased against the rural and urban informal economy. This is even though for most of the study countries, the informal economy is larger by far than the formal. Situating the implications of COVID-19 responses within existing structural inequalities between rural and urban,

formal, and informal economies, women, and men, between geographic regions, and rich and poor, it becomes clear that the implementation of COVID-19 measures created new forms of inequalities and a new poor.

Responses

Popular responses to COVID-19 impacts and government responses ranged on a wide spectrum between full compliance and protests. Some of the country studies examined the issue of compliance with COVID-19 measures from a variety of angles, including levels of compliance, who are least able to comply as well as the factors driving compliance and non-compliance. In several of the countries, there were generally high levels of compliance with containment measures.

On the other hand, measures judged to be unprecedented, draconian and against religious beliefs faced an uphill task in gaining acceptance. The lack of consultation was cited as an important factor in undermining compliance. A commonly offered reason for non-compliance was economic, that people could either not afford equipment such as face masks or hand sanitizer, or they would starve if they did. Mistrust of government was another important factor in non-compliance, and this was related to past events and the way they were handled. Compliance, no matter how high, initially, cannot be sustained without the participation of society in the design, implementation, monitoring and evaluation of measures.

That the handling of the COVID-19 pandemic by government has been mixed in success is evidenced by the numbers of complaints and protests from different quarters in all the twelve countries of study. While most protests registered in our studies and the media are a direct response to the handling of the pandemic, there are some that were triggered by the pandemic, though related to pre-existing governance crises.

The twelve country studies have demonstrated the four broad roles that CSOs, community organisations, associations, trades unions and workers associations, faith-based organisations and other spontaneous and loose formations and individual actors in the COVID-19 responses. These include monitoring responses and defending citizens from human rights abuses; demanding accountability and transparency in government spending decisions; information dissemination and curbing misinformation, and delivering services and providing palliatives (Obiakor, Iheonu & Ihezi, 2021). Civil society and other non-state actors drew mobilised resources from local and foreign sources to execute their programmes. Despite their pertinent roles, civil society faced immense challenges including marginalisation in decision making and wider COVID-19 restrictions that affected the way they reach their constituencies.

Innovations

The pandemic presented opportunities for innovations across the continent. There are widespread adoption of e-solutions and inventions, calls for return to African medicine and promotion of consumption of indigenous foods among many others. The largest number of innovations were ICT related particularly in the health, sanitation, and hygiene sectors. Several apps were developed for a range of health services connected with COVID-19 prevention and treatment, and digital platforms for connecting doctors and patients, including patients in remote areas, for managing patients' medical information. The production of medical, hygiene and sanitary equipment and devices was another strong area of innovation. To remedy the lack of infectious disease facilities, hospitals were constructed in record time with prefabricated and other technologies. All countries instituted e-learning systems including online learning

sites and platforms using telephone, television, or computers. In addition, educational innovations included software for distance learning, mobile classroom, and indigenous mobile learning platforms. COVID-19 has also highlighted a range of solidarity and self-help arrangements at the level of communities that provided food and other support to persons in crisis, as the limits of the state social security system was exposed by the crisis.

The commonalities in the innovations and inventions across our study countries are not remarkable given the similarities in both containment and mitigation measures across the globe. However, it is noteworthy that in Africa, there was interest in technologies and innovations that were appropriate and frugal, for situations with energy, technology, and financial deficits. While many of these interventions were borrowed from other contexts, they were innovative in the sense that they represented a new effort to envision a world in which African countries could rely on their own scientists and industries to produce vital needs. This is even more remarkable because of the wide gaps in ICT coverage between Africa and the world.

Based on these findings, country studies have made recommendations in five broad areas- strengthening data collection systems and policy institutions; economic support, social policy, and social services; participatory democracy and partnerships.

1.0 Introduction

For Africa, the COVID-19 pandemic has compounded decades of cyclical socio-economic and health crises and endemic challenges. While the pandemic's global character meant that all countries were facing a common threat, and therefore Africa did not have to carry the burden of opprobrium and exasperated charity by itself, there were the usual concerns expressed in dramatic scenarios and dystopian visions of extremely high death rates and total societal breakdown in Africa. The now often cited statement by Melinda Gates, co-chair of the Bill & Melinda Gates Foundation, in April 2020 that unless the world acts fast, dead bodies will litter the streets of Africa is one of the more dramatic expressions of concern[4]. However, the United Nations Commission for Africa (UNECA) also projected that without aid and intervention, up to 1.2 billion of the 1.6 Africans would be infected and between 300,000 to 3.3 million would die of Covid-19 (2020). That said, it was not all doom and gloom. A group of African scholars presented a more realistic projection of 150,078 deaths by May 2021 and between 16-26% of Africa's population infected within the first year of the pandemic (Cabore *et al.* 2020; See also Atuire and Rutazibwa, 2021 for a discussion of discourse on COVID-19 in Africa).

The fears about infection rates soon gave way to the search for explanations for Africa's relatively lower numbers of infections and deaths. Explanations that have been offered include the high malaria drug intake, early precautions taken by countries, intra continental and community resource and information sharing and the deployment of infrastructure inherited from Ebola containment measures at borders and health facilities. With regard to malaria, the finding of correlations between high malarial incidence rates and low COVID-19 prevalence rates led to suggestions that the intake of malarial drugs in countries with a high incidence of malaria could explain the low COVID-19 infections rates (Ahmed, 2020).

With respect to the timeousness of responses, many African countries responded early to the threat of COVID-19 compared with their slow response during the Ebola outbreak between 2013 and 2016. Even before the first COVID-19 cases arrived in Africa in February 2020, countries were ready to implement containment measures drawing on health system infrastructure and the experience of managing Ebola and other epidemics such as cholera (Maffioli, 2020; Chigudu, 2020).[5] At the ports of entry, countries relied heavily on the already existing health screening equipment and structures that were used during the Ebola outbreak. Health screening and interviews started very early, together with intensified public education and campaigns using WHO health advisories. Some countries also drew on their investments in public health capacity in HIV-AIDS, tuberculosis, malaria, polio, measles and other infectious diseases.

Demographic characteristics have also been cited as a possible reason for Africa's low rates of infections. Africa has a relatively youthful population with a median age of 18. This was thought to insulate the continent from the rapid spread and debilitating effects of the virus as compared with continents with aging populations. There is also a suggestion that Africa's socio-cultural practice of caring for the elderly at home, could partly explain the lower infection and mortality numbers.[6]

A third and more enduring public discussion, which is the subject of this synthesis report, has been about the implications of COVID-19 for Africa's economies, societies, democracies, institutions, and people in

[4] Melinda Gates: Covid-19 will be horrible in the developing world. (2020, April 10). In CNN Business. https://edition.cnn.com/videos/business/2020/04/10/melinda-gates-coronavirus.cnn-business

[5] For example, the 2008- 2009 cholera outbreak in Zimbabwe, described as the largest in African history recorded, 100,000 cases and about 5,000 deaths (Chigudu, 2020).

[6] It is well established that there have been high mortality in care homes in the Global North. For example, 81% of first wave deaths in Canada occured in care homes, while in South Africa, 33% of deaths occured in care homes (Adams, Mackenzie, Amegah et al. 2021; Ezeh, Merelli 2021, Silverman & Stranges, 2021).

the short and long term. An overarching question is the implications of COVID-19 for Africa's ability to achieve its development agendas within the framework of the SDGs and AU's Agenda 2063. A particular concern in this regard is whether COVID-19 would undo the progress that African countries have made with the SDGs and whether the pandemic would exacerbate the structural inequalities bedevilling African countries. The numerous webinars organised around the world in this period tackled some of these questions and interrogated the UN's agenda of "Building Back Better" from the pre-COVID era. What united many such efforts was their sense of urgency and a desire to seize the space afforded by this epochal event to push for a fundamental rethinking of Africa's development paradigms to promote meaningful structural transformation that would prepare Africa's economies and societies better for future pandemics and other crises, including climate change.

A by-product of these conversations has been the valorisation of African voices in discussions about Africa's future. This was considered critical at a time when all countries were caught up in their own crises and priorities. Paradoxically, some argued that the pandemic had exposed the interdependent nature of our world, and this therefore demanded international cooperation in the search for solutions (Williams, Kestenbaum and Meier, 2020). In the same vein, several commentaries decried the resurgence of populist nationalism,[7] drawing attention to its anti-democratic orientation, its strategic framing of health experts as elitist and its rejection of inconvenient scientific advice as well as its propensity to condone the violation of human rights, either directly or indirectly, and undermine the global health governance system (Williams et al, 2020).

The Aid community responded to the pandemic by investing in strengthening country responses. However, it is yet to respond to the challenges to its broader neoliberal austerity framework of the last four decades. In June 2021, G7 countries committed US$80 billion to support African countries to recover quickly from COVID-19[8]. While this was a good example of solidarity, it fell far short of the demand for an effective and sustained anti-COVID-19 response. Reports of AID reduction decisions by certain bilateral donors, vaccine nationalism, manifested by the blocking of access to vaccines by poor countries through hoarding, objecting to the liberalisation of licencing for vaccine production and the refusal to recognise vaccines produced outside certain geographical areas point to the continuing economic and political inequalities and hierarchies in the global order.

The relatively low infection numbers in Africa notwithstanding, there is concern about vaccinating Africa's populations because there is a pattern of new variants that are more infectious and, in some cases, more deadly than previous variants. For example, while Uganda recorded relatively low infections numbers during the first wave, the second wave which came with the Delta variant resulted in increased numbers of infections and mortality. This means that everyone needs timely and adequate protection since it is unclear guess what newer variants may bring. The current Omicron variant, which is said to spread faster and with less visible symptoms and is possibly not as deadly as the Delta variant for vaccinated persons, is a reminder that increasing the rates of vaccination everywhere should be a global imperative. In the discussions about access to vaccines, Africa's Aid dependence and the accompanying vulnerabilities, including the lack of policy autonomy, space to seize opportunities to build self-reliance and the compromised sustainability of innovations and inventions, have been topical in the policy discussions in this period.

[7] Nationalism is defined as seeking to turn states inwards, prioritising national interests over global interests, and populism is defined as a political strategy built on divisions and the pitting of the people against the elite to consolidate power (Williams, Kestenbaum and Meier, 2020).
[8] https://it.usembassy.gov/partners-bolster-africas-fight-against-covid-19-and-poverty/

The literature on COVID-19 and Africa as well as the numerous webinars and statements have also raised additional questions that are relevant to this synthesis. First among these is the question of the influence of country contexts, particularly existing stressors on the effects of COVID-19 and how state responses were received by the citizenry. This is key to understanding how the same sets of responses were exacerbating civil strife in some countries and not in others. A second question concerned the trade-offs between health and economy on the one hand, and between health and safety and human rights, rule of law and democracy on the other hand.

Thirdly, there was the conundrum of how Africa's teeming "hand to mouth" workers would survive the disruptions to the livelihoods because of lockdowns, land border closures and other restrictions in movements. Related to this was the implications of housing deficits and informal settlements without key amenities for the ability of people to adhere to COVID-19 health advisories. In this connection, the implications of online education for people in poor housing and the expansion of women's reproductive burdens and the increase in gender-based violence, were also issues of concern. Additional questions were a) the role of transformative social policy and measures such as universal basic incomes and services in addressing inequalities and the weaknesses of health and educational systems; and b) how to maintain and strengthen democracy and human rights and reduce state repression, corruption and actions that are threats to the integrity of nations.

It was in this early period of discussions about Africa and COVID-19 that the INCLUDE Platform's call for research between June 2020 and December 2021 on country studies on Africa's experience of COVID-19 was rolled out. Focused on a critical examination of containment and mitigation responses to the pandemic and their impacts in African countries, with special reference to marginalised, vulnerable and disadvantaged social groups, this project is one of several important efforts to respond to the imperative of research- based policy making, and to some of the questions enumerated above, particularly the issue of inequalities. This paper synthesises the findings from research conducted in the 12 countries selected for the study. The countries- Benin, Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Mozambique, Niger, Nigeria, Rwanda, Uganda, and Tunisia are spread across Africa and have interesting similarities and differences. Half of the countries are in West Africa, three in East Africa, and one each in North Central and Southern Africa.

The studies were guided by six broad themes:

- Country socio-economic contexts and pre-COVID conditions that have a bearing on COVID effects and responses.
- COVID-19 policy responses and measures in terms of i) nature ii) purpose iii) who they are directed at iii. b) their inclusivity and effects on different socio-economic groups (gender, race, ethnicity, and age); geography (rural; urban; North and South in certain countries), and on their implications for poverty and inequalities.
- The politics and implications of responses- a) origins and influences on measures; b) competing imperatives and reason for choices c) role of state and non-state actors; d) implications for structures and systems of power and governance and democratic consolidation; e) implications for state citizen relations, trust, and civic space.
- Citizen responses to containment and mitigation measures- from compliance, protests to innovations and inventions
- Gaps in knowledge and new directions for policy, research, and practice.

These themes were to enable an examination of inequalities arising from COVID-19 and responses and to identify who would be the most affected by containment measures and who would benefit from support and mitigation measures, and which pre-existing inequalities would be exacerbated or ameliorated by COVID-19 measures. The INCLUDE Platform's decision to highlight inequalities was driven by its own research priorities and the preliminary commentaries that were drawing attention to the risk of growing inequalities and their implications. COVID-19 was described as the inequality pandemic (Qureishi, 2020; Berkhout et al, 2021). Berkhout et al, writing in an OXFAM International briefing paper explain this characterisation as follows:

> *The coronavirus pandemic has the potential to lead to an increase in inequality in almost every country at once, the first time this has happened since records began. The virus has exposed, fed off and increased existing inequalities of wealth, gender, and race. Over two million people have died, and hundreds of millions of people are being forced into poverty while many of the richest – individuals and corporations – are thriving. Billionaire fortunes returned to their pre-pandemic highs in just nine months, while recovery for the world's poorest people could take over a decade. The crisis has exposed our collective frailty and the inability of our deeply unequal economy to work for all (Esmé Berkhout, et al, 2021).*

Antonio Guterres, UN Secretary-General, quite early in the pandemic, raised the question of inequalities:

> *COVID-19 has been likened to an x-ray, revealing fractures in the fragile skeleton of the societies we have built. It is exposing fallacies and falsehoods everywhere: The lie that free markets can deliver healthcare for all; The fiction that unpaid care work is not work; The delusion that we live in a post-racist world; The myth that we are all in the same boat. While we are all floating on the same sea, it's clear that some are in super yachts, while others are clinging to the drifting debris. –Antonio Guterres, UN Secretary General, 2020)*

The country studies researchers had the freedom to decide how to approach the study. Most of them were based on secondary sources and limited key informant interviews, with only a few of them undertaking surveys to collect quantitative data (Nigeria, Tunisia, and Benin). There is therefore some variability in what information is available in each report. However, the studies provide a core of comparative information on which this synthesis is based. Where necessary, we have drawn on official and unofficial statistical data from a variety of sources such as the WHO, World Bank, FAO, and the African CDC to discuss underlying/pre-existing economic, socio-cultural, and political conditions and the state of development; inequalities and vulnerabilities; strengths and weaknesses of institutions, infrastructure and services and questions of access. Secondary literature on COVID-19 has also been useful for triangulating some of the findings from the country studies.

This introduction is followed by a discussion of the economic, social, and political contexts, including stressors and crises, of the study countries at the start of the COVID-19 pandemic. This is followed by a presentation of COVID-19 effects, and the commonalities and specificities of containment and support measures that were put in place across the study countries. We examine which groups were most affected by the disruptions created by COVID-19 effects and containment measures, and who benefitted the most from support measures. The section which follows turns to the responses of non-state actors and examines the range of responses from compliance to riots and in between, the politics of responses and the roles of various actors and interest groups. One set of responses that we examine in some detail are innovations and inventions and the opportunities and challenges for uptake and sustainability. The last section of the synthesis discusses recommendations, gaps in our knowledge and new directions for policy, research, and practice for fashioning a durable response to the COVID-19 pandemic in Africa.

2.0 Country Background and Contexts

The effects of the COVID-19 pandemic and the responses of the governments of the study countries have been shaped in part by pre-pandemic country socio-economic and political contexts. There is certainly broad generic uniformity in Africa's COVID 19 experiences- low
infection rates and mortality rates, low levels of hospitalisations: common responses in terms of containment and support measures and massive economy wide disruptions because of the widespread informality of work, border closures and poor social policy. In terms of socio-economic contexts, eight (8) of the study countries (Benin, Burkina Faso, Ethiopia, Mali, Mozambique, Rwanda, and Uganda) are both low income and LDCs, while the other four (Ghana, Kenya, Nigeria, and Tunisia[9]) are lower middle income. LDC status denotes not just low per-capita income, but also significant social development deficits and environmental vulnerabilities. In the case of our study countries, there are several landlocked countries that are vulnerable to severe episodes of drought (Burkina Faso, Ethiopia, Mali, and Niger). Another common feature of several countries is the fact that their services sectors contribute the largest share (between 30 to 53%) of their GDP (Ghana, Kenya, Ethiopia, Nigeria, Rwanda, Tunisia, and Uganda). Even when it is not the most dominant, services are important for countries such as Mali and Niger. The size of the services sectors and their significance as a source of employment is a matter of concern because the Services sectors in Africa are dominated by small precarious enterprises, which except for ICTs, were very badly hit by the pandemic.

Labour force participation rates are generally high in the study countries, although women have slightly lower rates than men. The rates for women are between 49% (Nigeria) and 84% (Rwanda), with Tunisia as an outlier at 25%. For men, the figure is between 85% (Ethiopia) and 63% (Nigeria) (Table 2). Informal employment is the norm in most of the countries of study, ranging from 96.8% in Benin to 58.8% in Tunisia. Most countries are at 80.1% or higher, while Ghana and Niger are over 78%. Self-employment is the dominant form of employment in Africa, and this is no different for the study countries, apart from Tunisia, where wage work is 85.7% for women and 71.3% for men.

[9] Tunisia's per capita GDP is more than double that of the other Lower middle-income countries.

Table 1: Socioeconomic context of Study Countries

Country	Status	GDP per capita(current) (USD) 2019[10]	GDP per capita (LCU) 2019[11] (USD)	Sectoral composition of GDP (%)[12]				Sectoral composition of employment (%)		
				Agriculture	Industry	Manufacturing	Services, Value added	Agriculture (2019)[13]	Manufacturing/industry (2019)[14]	Services (2019)[15]
Benin	Lower-middle income	1, 219.4	1,259.8	27	16	10	48.0	*38	18*	43*
Burkina Faso	Low income (LDC)	786.9	822.2	20	26	10	44.5	26	25	49
Ethiopia	Low income (LDC)	855.8	602.6	34	25	6	37.1	67	9	24
Ghana	Lower-middle income	2, 202.1	1,884.3	17	32	10	44.1	30	21	49
Kenya	Lower-middle income (2020)	1,816.5	1,237.5	34	16	8	43.2	*54	6*	39*
Mali	Low income (LDC)	879.0	791.6	37	21	7	33.5	62	8	30
Mozambique	Low income (2019) (LDC)	503.6	588.7	26	23	9	39.9	70	9	21

[10] https://data.worldbank.org/indicator/NY.GDP.PCAP.CD
[11] https://data.worldbank.org/indicator/NY.GDP.PCAP.KD
[12] http://wdi.worldbank.org/table/4.2
[13] https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS
[14] https://data.worldbank.org/indicator/SL.IND.EMPL.ZS
[15] https://data.worldbank.org/indicator/SL.SRV.EMPL.ZS

Niger	Low income (LDC)	553.9	563.1	38	20	7	36.1	*73	7*	21*
Nigeria	Lower-middle income	2,229.9	2,374.4	22	27	12	49.7	35	12	53
Rwanda	Low income (LDC)	820.0	901.3	24	19	8	49.1	62	9	29
Tunisia	Lower-middle income	3,317.5	4,405.0	10	23	15	61.7	14	33	53
Uganda	Low income (LDC)	794.3	962.5	23	26	11	54.4	72	7	21

Source: World Bank Database

*Figures in the three columns do not add up to 100%

For most of the countries, waged work rates are between 6.2% (Benin) and 42.8% (Kenya) for women, and between 16.7% (Burkina Faso) and 58.4% (Kenya) for men. In addition to the gendered nature of wage and salaried work, there are also gender differences in the incidence of vulnerable employment, which is very high, between 98% (Niger) and 54% (Kenya) for women and 92% (Niger) and 41% (Kenya) for men. Here again, Tunisia is the outlier with 11% for women and 21% for men. An appreciable number of women workers are contributing family workers, who are in some of the most precarious forms of work (Table 2).

In terms of income poverty levels, the national headcount levels before COVID-19 range from between 15% for Tunisia, which is an outlier, 20-30% for Ethiopia, Ghana, Uganda, 31-40% for Benin, Kenya, Rwanda, between above 41 and 50% for Burkina Faso, Mali, Niger, and Nigeria, and above 50% for Mozambique. Over the years, income inequalities in many African countries have become wider, and this is a source of concern.

Income disparities are in some cases linked with high levels of poverty and in others not. Mozambique also has the worst score in income disparities (at 54%), while Benin, Ghana, Kenya and Rwanda and Uganda are between 40 and 48%) with Burkina, Ethiopia, Mali, and Nigeria and Tunisia between 32 and 36% disparities (Table 3). The observed pattern is that the countries which are poorest (LDCs), have higher levels of income poverty but lower levels of income disparity.

Table 2: Informal Employment Rates

Country (year)	Informal employment rate (%)[16]
Benin (2011)	96.8
Burkina Faso (2018)	95.4
Ethiopia	-
Ghana (2015)	78.1
Kenya (2017)[17]	83.4
Mali (2018)	93.4
Mozambique (2015)	95.7
Niger (2017)	78.2
Nigeria (2018)[18]	92.9
Rwanda (2019)	80.1
Tunisia (2018)[19]	58.8
Uganda (2017)	89.4

Source: ILO Database

[16] Last update 20 May 2021. Informal employment includes own-account workers outside the formal sector, contributing family workers, employers, and members of producers' cooperatives in the informal sector, and employees without formal contracts. Source: https://ilostat.ilo.org/topics/informality/

[17] Kenya National Bureau of Statistics (2018). Economic Survey, 2018. Nairobi: KNBS

[18] ILO (2018). *Women and men in the informal economy: a statistical picture (third edition)* / International Labour Office – Geneva: ILO

[19] ibid

Table 3: Poverty Levels in Study Countries

Country	National	Gini index Income disparities (%)[20]
Benin	38.5(2019)	47.8 (2015)
Burkina Faso	41.4(2018)	35.3(2014)
Ethiopia	23.5(2015)	35.0(2015)
Ghana	23.4	43.5(2016)
Kenya	36.1(2015)	40.8(2015)
Mali	42.1(2019)	33.0(2009)
Mozambique	53.5[21]	54.0(2014)
Niger	40.8(2018)	34.3(2014)
Nigeria	40.1(2018)	35.1(2018)
Rwanda	38.2(2016)	43.7(2016)
Tunisia	15.2(2015)	32.8(2015)
Uganda	21.4(2016)	42.8(2016)

In the case of Tunisia, higher per capita income combined is relatively low levels of income poverty and income disparities. Mozambique bucks this trend by being an LDC with the highest headcount poverty and income disparities. Both high levels of poverty and income inequalities are economic stressors that can make countries socially fragile and politically volatile (Table 3).

Going by the selected social development indicators, stunting in children under 5 years, is under 10% for Tunisia, under 20% for Ghana; between 20 and 29% for Burkina, Kenya, Mali, and Uganda; between 30 and 39% for Benin, Ethiopia, Nigeria, and Rwanda, and over 40% for Niger and Mozambique. The two proxies for gender inequalities, violence against women and literacy rates were selected for their relevance to discussions about COVID-19 effects as several commentaries had predicted an increase in violence against women and the widening of gender gaps in educational attainment.

Regarding literacy rates of persons 15 years and above, the countries with the lowest rates (between 30-39%) are Mali and Niger. Burkina Faso and Benin have between 40% and 49%, Nigeria, Ethiopia and Mozambique have between 50% and 69%, while Ghana, Rwanda, Tunisia, Uganda, and Kenya have between 70 and 89%. The gender gap in literacy is up to 10% for Ghana, Kenya, and Rwanda; between 11 and 20% for Burkina Faso, Ethiopia, Mali, Niger, Nigeria, Tunisia, and Uganda; and above 20% for Benin and Mozambique. Physicians per 1,000 people is 0.0 for Niger, 0.1 for Benin, Burkina Faso, Ethiopia, Ghana, Mali, Mozambique, and Rwanda; 0.2 for Kenya; 0.4 for Nigeria, and 1.3 for Tunisia.

[20] https://data.worldbank.org/indicator/SI.POV.GINI?locations=MZ
[21] https://www.mef.gov.mz/index.php/documentos/estudos/artigos/752--150/file?force_download=1

Table 4: Selected Social Development Indicators of Study Countries

Country	Prevalence of stunting, height for age (% of for children under five)[22]	Violence against women[23]	Literacy rate, adult total (% of people ages 15 and above)			Physicians per 1000 people[24]	Nurse and midwives per 1000 people[25]	Main inequalities[26]
			Adult[27]	Male[28]	Female[29]			
Benin	32.2(2018)		42(2018)	54	31	0.1(2018)	0.4(2018)	Gender, location (rural-urban)
Burkina Faso	23.8(2019)	9.3 (2010)	41(2018)	50	33	0.1(2017)	0.9(2017)	Gender, rural-urban
Ethiopia	36.8(2019)	19.8 (2019)	52(2017)	59	44	0.1(2018)	0.7(2018)	Gender, region, rural urban
Ghana	17.5 (2017)	27.7 (2015)	79(2018)	84	74	0.1(2017)	4.2(2018)	Gender, region (North-South), location (rural urban)
Kenya	26.2(2014)	40.7 (2014)	82 (2018)	85	78	0.2(2018)	1.2(2018)	Gender, rural - urban
Mali	26.4(2019)	21.5 (2006)	35(2018)	46	26	0.1(2018)	0.4(2018)	Gender, rural-urban
Mozambique	42.3(2015)	15.5 (2015)	61 (2017)	73	50	0.1(2018)	0.7(2018)	Gender, geography, and location
Niger	47.1(2019)	-	35(2018)	44	27	0.0(2016)	0.3(2016)	Gender, rural urban
Nigeria	31.5(2020)	11.0 (2013)	62(2018)	71	53	0.4(2018)	1.2(2018)	Gender, region, rural-urban
Rwanda	33.1(2020)	20.7 (2015	73(2018)	78	69	0.1(2018)	1.2(2018)	Gender, rural-urban
Tunisia	8.4(2018)	-	79(2014)	86	72	1.3(2017)	2.5(2017)	Gender, rural-urban
Uganda	28.992016)	29.9 (2016)	77(2018)	83	71	0.2(2017)	1.2(2018)	Gender, rural-urban

The nurse/midwife patient ratio is better for all countries- 0.3 in Niger, 0.4 in Benin and Mali; 0.7 in Ethiopia and Mozambique; 0.9 in Burkina Faso; 1.2 in Kenya, Nigeria, Rwanda and Uganda; 2.5 in Tunisa, and 4.2 in Ghana. In terms of inequalities, all countries identified gender and rural-urban inequalities as important. In addition, Ethiopia, Ghana, Mozambique, and Nigeria identified geographical or regional inequalities. The pre-COVID 19 conditions described above provide a sense of vulnerabilities and points of resilience in the study countries (Table 4). In terms of the pre-COVID situation, reported cases of

[22] https://data.worldbank.org/indicator/SH.STA.STNT.ZS
[23] https://data.worldbank.org/indicator/SG.VAW.1549.ZS
[24] https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=BJ
[25] https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=BJ
[26] Oxfam International (2019). The West African Inequality Crisis: How West African Governments are failing to reduce inequality, and what should be done about it. Oxford: Oxfam

[27] https://data.worldbank.org/indicator/SE.ADT.LITR.ZS
[28] https://data.worldbank.org/indicator/SE.ADT.LITR.MA.ZS
[29] https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS

violence against women was under 10% for Burkina Faso, between 10- 19% in Ethiopia, Mozambique, and Nigeria; between 20 and 29% in Ghana, Mali, Rwanda, and Uganda; and 40.7% in Kenya (Table 4).[30]

All the study countries were identified as multi-party constitutional democracies with ruling and opposition parties. However, for many of the study countries, COVID-19 represented a crisis within a crisis. Niger, Burkina Faso, and Mozambique were facing Islamic insurgencies of different degrees of severity, which had generated feelings of insecurity among the population. In the case of Burkina Faso, this had been compounded by the closure of 7.2% of health facilities in 2020 affecting 1.08 million people (OCHA, 2020). Ethiopia was on the brink of civil war and Tunisia has been in the throes of political instability, unsettled since the Arab Spring. A decision to postpone elections to contain COVID-19 has deepened instability and tension in Ethiopia. In Mali, a longstanding political crisis has resulted in coups d'état in August 2020 and May 2021. In Nigeria, the crisis has been manifested by a generalised breakdown of security, police/armed forces brutality and mistrust of government, which at the height of COVID-19 boiled over into the End-SARS campaign. Kenya was facing a crisis of terror attacks and police brutality, while Rwanda's main political stressor was its closed political system, government intolerance of criticisms and compliant CSOs. In Ghana, Uganda, Benin and Niger, elections heightened political tensions, partisanship, and distrust for government, with citizens expressing suspicion of government intentions and about the seriousness of the pandemic in equal measure. In the case of Uganda, political repression and police brutality had created a volatile situation. In the context of elections, opposition parties and segments of the population considered mitigation measures as a strategy by government to curry favour with electorates or score political points; while containment measures were seen as strategies to demobilise opposition parties from campaign activities during elections (Table 5).

[30] No figures were obtained for Benin, Niger, and Tunisia.

Table 5: Politics and Governance Context

Country	Political system	Use of decentralisation for COVID-19	Political stressors
Benin	Multiparty Constitutional Democracy	Used	Elections in 2021
Burkina Faso	✔	Not stated	Political and religious extremism/ insurgency and feeling of insecurity and closure of 7.2% of health facilities affecting 1.08 million people
Ethiopia	✔	Not stated	Postponement of general elections Ethnic conflict and increased insecurity in some regions
Ghana	✔	Not stated	Election in December 2020 Mistrust of government
Kenya	✔	Used	Terrorism and police brutality
Mali	✔	Used	Islamic Insurgency Coup- d'état and insecurity
Mozambique	✔	Used	Insurgency and attacks
Niger	✔	Not stated	Elections in 2021
Nigeria	✔	Federal level	Police brutality Insurgency Mistrust of government
Rwanda	✔	Used	Closed political system and compliant CSOs
Tunisia	✔	Used	Political instability, terrorist attack
Uganda	✔	Used	Elections in 2021, political repression and police brutality

Sources: Authors' construction based on literature review and country cases

Table 8: COVID-19 Community Vulnerability Index (CCVI) by Country								
Country	**CCVI SCORE**							
	Overall CCVI	**Age**[31]	**Epidemiological**[32]	**Fragility**[33]	**Health System**[34]	**Pop. Density**	**Socioeconomic**[35]	**Transportation and Housing**[36]
Benin	0.31	0.40	0.09	0.34	0.63	0.66	0.74	0.49
Burkina Faso	0.43	0.26	0.23	0.89	0.46	0.37	0.77	0.69
Ethiopia	1.00	0.29	0.03	0.94	1.00	0.54	0.94	1.00
Ghana	0.00	0.83	0.06	0.11	0.20	0.69	0.00	0.11
Kenya	0.23	0.37	0.77	0.37	0.23	0.77	0.11	0.46
Mali	0.46	0.14	0.31	0.97	0.74	0.26	0.89	0.34
Mozambique	0.74	0.23	0.54	0.86	0.51	0.20	0.91	0.66
Niger	0.86	0.06	0.14	0.69	0.66	0.29	1.00	0.91
Nigeria	0.09	0.11	0.00	0.49	0.57	0.86	0.37	0.20
Rwanda	0.03	0.00	0.17	0.71	0.14	0.97	0.14	0.31
Tunisia	-	-	-	-	-	-	-	-
Uganda	0.11	0.17	0.26	0.26	0.09	0.83	0.26	0.74
Source: The Africa COVID-19 Community Vulnerability Index (CCVI)								

[31] Number of people aged 65+
[32] Non-Communicable Diseases, HIV prevalence, infectious diseases prevalence, smoking, and BCG vaccination
[33] Civil unrest, food insecurity
[34] Health system strength, health system capacity, and access to health care
[35] Access to information, education, poverty, and unemployment
[36] Household crowding, improved housing, sanitation, access to transportation, and road connectivity

Since the outbreak of COVID-19, there have been efforts to classify countries according to their vulnerability to the pandemic. The COVID-19 Community Vulnerability Index (CCVI),[37] which measures the vulnerability context of countries using their age structure, epidemiological context, fragility, health system, population density, socioeconomic structure and transportation and housing systems is one such effort. The index finds, based on all seven indicators, that Ghana is the least vulnerable (CCVI Score-0.00), while Ethiopia is the most vulnerable, and Tunisia is missing from the index. Other countries with high vulnerability scores are Niger, Mozambique, Mali, Burkina Faso, and Benin in that order (CCVI score:1:00) (Table 4). An examination of each indicator separately shows that on age vulnerability (number of people aged 65 years and above), Ghana is the most vulnerable while Rwanda is the least vulnerable. On epidemiological vulnerability, Nigeria is the least vulnerable, while Kenya is the most vulnerable. On the fragility measure, which looks at civil unrest and food security, Ghana is the least vulnerable while Mali is the most vulnerable. With respect to health systems vulnerability, Ethiopia is the most vulnerable while Uganda is the least vulnerable. Ghana is the least socio-economically vulnerable, while Niger is the most vulnerable. For transportation and housing, Ethiopia is the most vulnerable while Ghana is the least vulnerable. In terms of population density, Rwanda is the most vulnerable and Mozambique is the least vulnerable (Table 8). It is instructive that the most vulnerable countries are all LDCS, and except for Mozambique, landlocked with high levels of social tension. While useful in flagging stressors that need attention, differences within countries are not reflected in the measurement. Thus, Ghana's high score conceals the regional, rural urban, class, and gender differences in the vulnerability context.

3. COVID-19 Impacts

Disease burden

The impacts of the COVID-19 pandemic are difficult to distinguish from the impacts of external and national containment and mitigation responses, and their interaction with pre-existing conditions. With this in mind, we identify two kinds of impacts in the country studies- a) infection and mortality rates and b) socio-economic and political impacts. As of 3rd September 2021, COVID-19 infection and mortality rates were quite modest when compared with what countries in the Americas (84,498, 889 cases), Europe (65, 697, 497 cases), South-East Asia (41,504,688 cases), Eastern Mediterranean (14, 776, 814 cases), Western Pacific (6, 778,828 cases) had experienced. Africa recorded the lowest numbers of infections with 5, 689, 356 cases.[38] While there may be question marks about Africa's infection and mortality statistics because of the generally poor medical data collection and management systems, low diagnostic and testing capabilities and rates of testing and surveillance, there is evidence to suggest that infections and related mortality numbers are relatively low. There is currently a third wave of the COVID-19 pandemic, and there is already emerging evidence that some countries such as Uganda and South Africa are experiencing increased infection rates, it is unclear which other countries in our sample will experience quite serious infection levels. Given the low rates of vaccination (2.93% of Africa's population) and the crisis of the COVAX facility, there is cause for worry.

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[37] An index that assesses health, economic and social impacts of COVID-19 in Africa(https://precisionforcovid.org/africa)

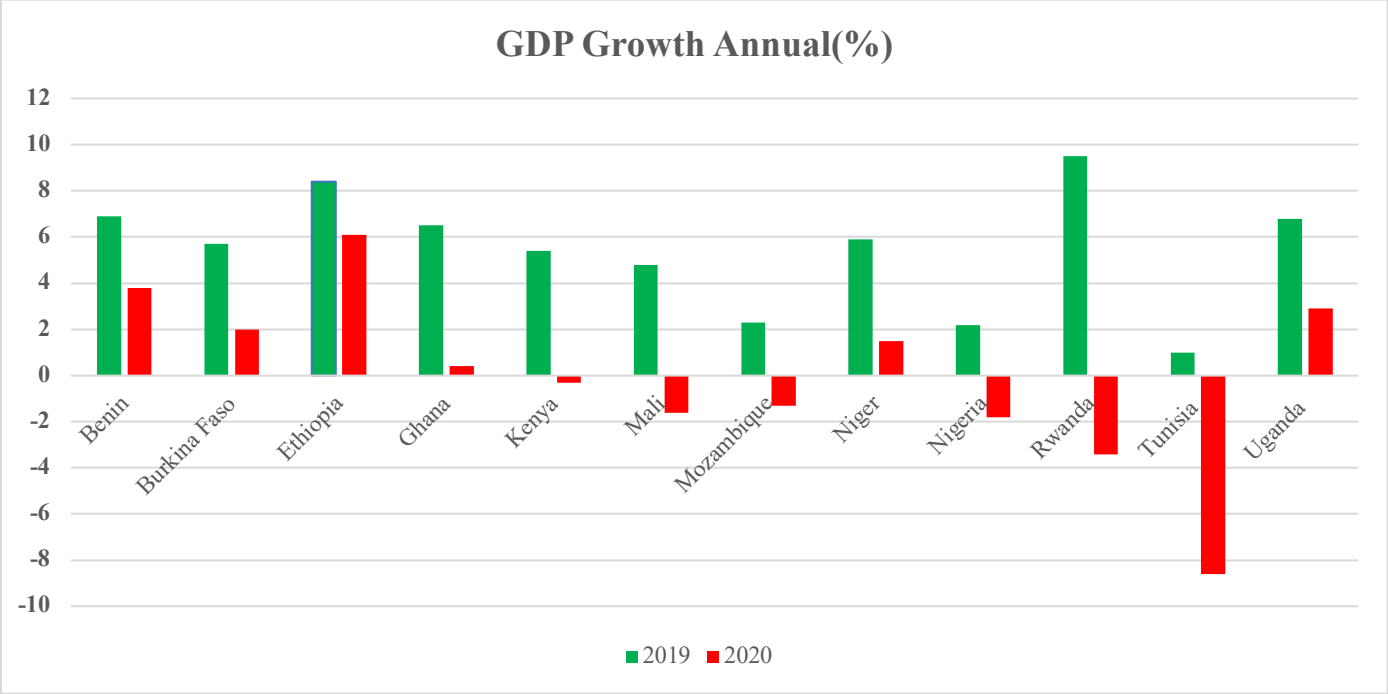
WHO Coronavirus (COVID-19) Dashboard https://covid19.who.int/

The impacts of COVID-19 on access to health in countries in SSA has not been as devastating as earlier predicted based on expected infection rates and the major deficits in health facilities and problematic doctor and nurse patient ratios in all our countries. Data from the COVID-19 Household Monitoring Survey showed that at in Ghana, Kenya and Mali for example, 90 percent of survey respondents in June 2020 reported having been able to access health care while the figure for Nigeria was 66%. In Uganda, while many respondents accessed health facilities, those who reported that they could not do so cited lack of money or transportation challenges rather than reduced access due to covid-19 infections.

Economic Contraction

Much more troubling for Africa have been the socio-economic impacts of COVID-19, such as economic contraction, livelihood disruption, food insecurity and growing inequality. The African Development Bank (2021) described the levels of contraction of economies in Africa as a recession, the severest witnessed in half a century. In general, African economies contracted by 2.1%, with tourism, oil, and other natural resource extraction the hardest hit. Debt to GDP is expected to increase by about 15% in 2021 because of COVID-19. Annual GDP growth declined sharply from impressive 2019 figures for many countries- Kenya (-0.3%), Mali (-1.6%), Mozambique (-1.3%), Nigeria (-1.8%), Rwanda (-3.4%) and Tunisia (-8.6) recorded negative growth in 2020 (see figure 1).

Figure 1: GDP Growth Annual (%)- 2019-2020



Source: World Bank National Accounts Data/OECD National Accounts Data[39]

[39] World Bank national accounts data, and OECD National Accounts data files. (https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG)

The decline in the tourism, transportation, trade, and the extractive sector drove the economic decline. Remittance flows also declined by 12.5 percent in SSA, with Nigeria alone contributing 28% of the decline.[40] Ghana (5%), Kenya (9%) and Mozambique (16%), on the other hand, recorded increases in remittances (The International Bank for Reconstruction and Development and the World Bank 2021). It is not clear what accounts for the differences between the various countries.

Livelihood disruptions and loss of employment income.

The socio-economic structure of African economies presents various forms of inequalities. In the African context, a marker of inequality that is widely discussed and visible is informality. Apart from a few economies in Northern Africa- Morocco, Egypt, Tunisia, Algeria, Libya, and South Africa, many of Africa's economies are largely informal. Most workers are either self-employed or in casual wage employment with precarious working conditions that have a negative effect on incomes, health, housing, education, and general wellbeing. It has been widely acknowledged that the informality of economies, the inequalities and inadequacies of incomes and living conditions have affected compliance with COVID-19 regulations. For example, vulnerable people, who eke out a living on the streets and in slums are expected to adhere to containment rules that disrupt their livelihoods and push them deeper into poverty (Amadasun, 2020).

The lack of effective coordination in COVID-19 responses between African countries resulted in the harsh treatment of traders and other economic actors at border crossings (Kamazima, 2020; Kamazima, Kazaura & Kakoko, 2020). Many land borders across Africa remain closed since March 2020. This has been contrasted with the early opening of Airports, which are patronised by the rich as illustrative of the neglect of the poor amidst the prioritisation of the rich. Although governments gave them some exemptions, workers in sectors permitted to work such as market traders, transporters, and other essential workers, still had to justify their presence to security personnel, and in some cases, they suffered ill-treatment despite the exemptions.

Paci (2021) using World Bank's COVID-19 High-Frequency Monitoring Dashboard found significant negative effects on livelihoods, food security, education and health in countries surveyed in May and June 2020. The statistics show that the effects of the pandemic differ significantly by location as urban areas are the most affected by declining unemployment and livelihood disruptions. In terms of gender, more women in urban areas lost jobs and suffered other disruptions to their livelihoods than men. Disruptions in the economy also affected household businesses. A third of households in Kenya, Nigeria, and Ethiopia shutdown businesses at the initial stages of the pandemic and revenues from family enterprises fell by over 70% in Uganda and Mali (Paci, 2021).

Massive job losses have been recorded in the case study countries. For example, 62% of Kenya's working population suffered job losses in June 2020. Other examples include Ghana (29%), Mali (29%), Uganda (19%) and Burkina Faso (12%). As expected, income losses accompanied the job losses with 66.4% of survey respondents reporting income loss in Ethiopia, 91% in Uganda and 79.3% in Zambia. In Nigeria, the National Longitudinal Phone Survey **(**NLPS 2020) found that by June 2020, 45 per cent of Nigerians surveyed had simply stopped working (Obiakor, Iheonu & Ihezi, 2021). At household levels, labour income losses were ubiquitous. Eighty per cent of NLPS respondents reported some level of income loss.

[40] Nigeria accounts for 40% of remittance flows to SSA and minus Nigeria, the remittance inflows will increase by 2.3%.

Decomposing job losses showed differences among groups of workers. In Nigeria, the decrease in household income was prominent for households engaged in non-farm activities. For the field survey, 93 per cent of respondents reported an income decrease of at least 50 per cent in current incomes due to the lockdowns. Ninety-five per cent of informal sector respondents compared with 86 per cent of those in the formal sector reported income decreases. All respondents operating in the agricultural, fishing, poultry, food service, construction and domestic work sectors reported a level of loss in income. In all other sectors under review, above 90 per cent of respondents reported a level of loss in individual and household incomes. The most affected workers were those operating in food services (28.8 per cent) and the wholesale and retail sectors (11.6 per cent), which are highly informal (Obiakor, Iheonu & Ihezi, 2021). Reduction in consumption was one of the main effects of the crisis on households. Forty per cent of Kenyans and 10% of Malians reduced consumption because of income, job, and income losses (Paci, 2021)

Deepening Inequalities in access to essential amenities

The COVID-19 pandemic has exacerbated pre-existing conditions of household inequality particularly in incomes and earnings, access to food, water, hygiene, sanitation infrastructure and electricity. This has created additional vulnerabilities to the poor. Ekumah, Armah, Yawson *et al* (2020) using data from 25 African countries found that except in South Africa, 46% of households sampled did not have water, sanitation, and food storage facilities in-house. Only 8% had access to all three basic needs in-house. In five countries, only 2% of the surveyed households had access to these necessities in-house while in ten countries, 50% of households had no in-house access. The situation was even worse for rural and urban slum households, female headed and poor households. These dimensions of inequality are also distinguished by race, class, and indigeneity, particularly in South Africa (Arndt, Davies, Gabriel, et al. 2020; Finn & Kobayashi 2020).

These inequalities in access to basic needs has meant that the poor bear the heaviest burden of the COVID-19 pandemic containment measures as studies in Ghana have demonstrated (Dzigbede & Pathak 2020; Oduro and Tsikata, 2020). Africa's urban populations, mostly live-in informal housing structures without health, sanitation, and other vital amenities. The demolition of informal settlements during the early days of COVID-19 by the state apparatus in South Africa and Ghana are an example of state-led stigmatisation campaigns against the poor, who are considered the vectors of the disease. The failure of public health institutions to domesticate containment advisories drawn from international sources highlight the fault lines of structural inequality in many countries. Furthermore, the uniform application of advisories such as lockdowns, quarantines, social distancing, and work from home, will deepen inequalities. This is because of the uneven distribution of COVID-19 transmission risks and livelihood shocks.

Children's education has also been affected although virtual learning programmes were implemented in many countries. The level of uptake in online lessons varied from country to country. For example, while 88% of households with school children in Burkina Faso were engaged in learning activities in June 2020, only 36% of households in Mali with children reported that children were engaged in virtual learning activities (Paci, 2021). School closures have also affected children who depended on school feeding programmes. With the shifting of the state's social responsibility to households, women must shoulder the burden of care.

Food Insecurity

An increase in the incidence of hunger and deepening food insecurity have been identified as a key impact of the COVID-19 pandemic across Africa and beyond. General improvements in the food security situation in many countries over the years notwithstanding, food insecurity and child malnutrition have remained a problem in several African countries and is often exacerbated by crises. In several of the study countries, even before the pandemic, food insecurity had been worsened by armed and Islamic insurgency in Mozambique, Mali, Niger, Burkina Faso and Nigeria, natural disasters such locust invasion in Ethiopia, Kenya and Uganda and cyclone IDAI in Mozambique. In Mali, the FAO (2020) estimated that 280,000 more people were exposed to food security due to COVID-19 and another one million would face food security challenges due to conflicts.[41]

Table 9: Food Security Situation of Case Study Countries

Country	Prevalence of undernourishment in the total population	Prevalence of severe food insecurity in the general population	Prevalence of wasting in children under 5	Prevalence of stunting in children under 5	Prevalence of anaemia among of reproductive age (15-49)
	2018-20			2020	2019
Benin	7.6	-	5.0	31.3	55.2
Burkina Faso	4.4	15.4	8.1	25.5	52.5
Ethiopia	16.2	16.4	7.2	35.3	23.9
Ghana	6.1	8.6	6.8	14.2	35.4
Kenya	24.8	25.7	4.2	19.4	28.7
Mali	10.4	-	9.3	25.7	59.0
Mozambique	31.2	40.5	4.4	37.8	47.9
Niger	-	-	9.8	46.7	49.5
Nigeria	14.6	21.4	6.5	35.3	55.1
Rwanda	35.2	-	1.1	32.6	17.2
Tunisia	3.0	10.7	2.1	8.6	32.1
Uganda	-	21.7	3.5	27.9	32.8

FAO, 2021

While the Global Hunger Index scores showed a decline or stability in the hunger situation in most of the study countries, the scores for Nigeria (29.2) and Mozambique (33.1) increased over their 2019 figures of 27.9 and 28.8 respectively[42]. Even in countries with stable hunger indices, significant numbers of people were facing severe food insecurity prior to COVID-19 in the case study countries (see table 9). Since the pandemic, food price inflation and volatility, food shortages as well as the high levels of income loss and livelihood disruptions have increased the risks of food insecurity. In Benin, more than 95% of respondents reported an increase in the prices of maize, sorghum or millet, rice, gari[43], beans, pepper, peanut oil, and

[41] FAO committed USD 10 million to support protect the livelihoods of 65,000 rural household who were experiencing new forms of severe and acute food insecurity.

[42] https://www.globalhungerindex.org/download/all.html

[43]Local food made of ground cassava, dried, and roasted

palm oil during the lockdown. This reduced to 85% the post-lockdown period although it remained higher compared to pre-covid 19 period.

Table 10: Foods Prices Variability in Benin during COVID-19

Some Foodstuffs	During lockdown (%)		Post lockdown (%)	
	Price increase	Price drop	Price increase	Price drop
Maize	96.06	3.94	83.86	16.14
Sorghum / Millet	97.42	2.58	82.50	17.50
Rice	98.43	1.57	83.27	16.73
Gari	97.42	2.58	89.98	10.02
Bean	98.06	1.94	87.06	12.94
Pepper	92.97	7.03	80.17	19.83
Peanut oil	99.28	0.72	86.12	13.88
Palm oil	95.95	4.05	89.80	10.20

Source: ASE Data Collection, December 2020 cited in Wantchekon & Koumassa,2021

Similarly in Tunisia, households' expenditure on food increased from 14.4% to 21.3% (UNDP, 2020). In Ghana, food inflation rose in March 2020 and declined from July 2020, during the harvesting season and rose again in November 2020. Since May 2021, it has been rising again. The Jollof Rice Index in Nigeria indicates that in "March 2021, the average cost of making a pot of Jollof rice for the average Nigerian family stood at ₦7,124 but has increased up to ₦7,618 in June 2021, marking a 6.93% increase within a period of three months".[44] The findings of a survey in Nigeria summarizes the problems that many of our study countries faced:

> *According to "NLPS 2020, 85 per cent of households experienced increases in the prices of staple foods and 55% of households dealt with income shocks by consuming less food. Even for respondents who did not experience a reduction in income, rising food prices reduced their food consumption (Obiakor*, Iheonu & Ihezi, 2021, pp:16).

Several factors were particularly significant for COVID-19 induced food insecurity. Lockdowns for example affected the food security of both households above and below the income poverty threshold. In Mali, approximately 33% of poor and non-poor households did not have enough to eat during the COVID-19 lockdown period (Traoré & Diarra, 2021). However, this figure declined in the follow up survey. In Kenya, 86% of households reported not having enough food to eat (Ferguson, Satchi, Kizito & Kuria, 2021). In Nigeria, 80% of surveyed households reported not having enough food to eat and in Ethiopia and Nigeria,

[44] https://reliefweb.int/report/nigeria/jollof-index-q2-2021-food-prices-enter-geostationary-orbit-july-2021

households that ordinarily have food all the time made adjustment to their food consumption needs (Obiakor, Iheonu & Ihezi, 2021; Teshager & Chofana, 2021). For example, 10% of rich households in the Nigeria survey population reported having ran out of food within 30 days of lockdown. In addition to household income levels, there were regional and rural-urban differences in the experience of food insecurity (Obiakor, Iheonu & Ihezi, 2021). A survey in Uganda found that 17% of Kampala dwellers faced acute food shortages (Ferguson, Lambert-Peck, Kapsandui & Kuria, 2021).

In Ethiopia, rural people reported short-term food shortages, although they were generally more food secure than their urban counterparts. Regions such as Somali, Afar and Tigray faced more food insecurity (Teshager & Chofana, 2021). Households with children in school feeding programmes have been severely affected in countries such as Nigeria, Kenya, and Ghana due to discontinuation of the programme because of school closures.

In the study countries, households have been coping with food insecurity in a variety of ways. The most common have been to reduce food intake, buy only a few essential food items, borrowing to buy food, adults forfeiting food to feed their children, sex for food in Uganda and Kenya Ferguson, Satchi, Kizito & Kuria, 2021; Ferguson, Lambert-Peck, Kapsandui, & Kuria ,2021 , sale of productive assets such as livestock and land in Uganda and illegal activities to acquire food such as theft In Tunisia, speculation and monopolisation of some food supply chains affected the food system which resulted in 300 daily reports of such practices (Hassen, Ali & Wojcieszynski, 2021). Consequently, state authorities seized essential food items such as semolina, subsidised flour, and vegetable oil from offenders. There were also arrests of people who were smuggling semolina to Algeria.

A recent study by Mkhabela (2020) on food insecurity in the Southern Africa region confirms these findings from the country studies. The study found that COVID-19 and the measures to contain it are already having a negative and gender-differentiated impact on all dimensions of food security and nutrition, through reduced food production and distribution capacities, decreased purchasing power and diminished access to nutritious food. The study found that an estimated 45 million citizens in 13 SADC countries are food insecure with COVID-19 negatively impacting the capacity of citizens to produce, purchase and even move staple foods because of blanket lockdown measures. In addition to homes, this situation was affecting the food service sector and its workers- in restaurants, pubs, food courts and fast-food outlets, itinerant food vending, farmers' markets, and artisanal food stall pop-ups. This is certainly a global trend with regional specificities. As Mkhabela notes, the pandemic is magnifying the disparities in local food environments faced by different social classes, with gender intersecting with race, ethnicity, immigration status, disability, age, and other dimensions of social difference.

In the section that follows, it will become clear how responses to COVID-19 have deepened already existing inequalities between income groups, livelihood sectors, rural and urban areas, and men and women.

4. Containment and Mitigation Responses by State and non-State actors

Containment measures: Proactivity and Compliance in states of high uncertainty.

The first consideration of a public health emergency concerns how to balance health challenges without hurting the economy. As Chigudu (2019) notes, epidemics have political, economic, and social dimensions and therefore responses determine who lives and who dies. Although African countries have varied capacities in terms of disease control, surveillance, and health infrastructure most countries responded early to the threat of COVID-19 compared with their slow responses during the Ebola outbreak in 2013-2016. Even before the first cases were recorded in Egypt on February 14th, 2020, countries were ready to implement containment measures (Maffioli, 2020). At ports of entry, countries relied heavily on the already existing health screening equipment and structures that were used during the Ebola outbreak. Health screening and travel histories data collection were started early in February 2020. Similarly, public education and campaigns intensified mainly drawn from country experiences and from continental and global bodies such as the Africa-CDC and WHO.

Continental bodies took the initiative to forge a common response to the pandemic. The African Union's timely initiatives added to the capacities of countries. The AU conducted a COVID-19 readiness assessment very early, formulated a continental strategy and had several ministerial engagements to develop a continental response strategy. The African Centre for Disease Control (Africa-CDC) started monitoring reports in international media about the breakout of the pandemic in Wuhan early in 2020. Immediately the first case was recorded on the continent, the African CDC held an emergency meeting with the African Union to brainstorm strategies to deal with the COVID-19 pandemic. A Joint continental COVID-19 strategy was adopted at the meeting. By 27th of January 2020, the African CDC had activated its emergency operations centre to monitor the COVID-19 situation. It held regular virtual meetings with health experts and institutions across the continent and had weekly press briefings to ensure openness and accountability through information sharing.

In July 2020, the Africa CDC put together a Consortium for COVID-19 Vaccine Clinical Trials (CONCVACT) to coordinate vaccine trials, training of experts, set up vaccine review boards, and share information on the vaccines. The CONCVACT has established partnerships across the globe to work together on vaccine trials. The AU Commission and the Africa-CDC organized a virtual conference in June 2020 with the participation of over 300 stakeholders including politicians and technical experts to discuss the COVID-19 vaccine, emphasizing the need for a continental strategy for vaccine acquisition. This was followed by a meeting convened in August by the African Union Bureau of Heads of States and Governments, which approved the Africa CDC's strategy to act collectively to access vaccines.

The African CDC also provided technical support and medical supplies to member states and medical supplies were delivered by the leading continental airline, Ethiopian Airlines. The Africa Export Import Bank (Afreximbank), established in 1993 by AU member states to promote trade within the continent has also been at the forefront of the COVID-19 vaccine financing regime. Together with the African CDC, the bank has developed a financing strategy for vaccines and other essential medical supplies and committed $4 billion to

this initiative. The Africa Medical Supply Platform (AMSP) which was set up by the Africa CDC and other partner institutions have developed a system to coordinate the distribution of vaccines (Nkengasong, Ndembi, Tshangela & Raji 2020). The AMSP has already pre-ordered vaccines for 55 African countries[45]. On its website in February 2021, the AMSP displayed vaccines from three companies namely Johnson and Johnson, AstraZeneca, and Pfizer. And by a click of an icon, one gets to make orders. In addition, the platform also promotes made in Africa medical supplies by linking suppliers and customers.

By 14th January 2021, the Africa Union with its partner institutions such as the United Nations Economic Commission for Africa (ECA) and bilateral donors such as, Governments of China, Canada, France and other continental partner institutions and foundations had acquired 270 million doses of vaccines through the COVID-19 African Vaccine Acquisition Task Team (AVATT) and as part of the Africa Vaccine Strategy (AVS). Afreximbank will guarantee payment on behalf of the member states. The institutional coordination by the various institutions has shielded weaker states, made resources available to all countries and ensured that the continent presented a united front in its pandemic response. This Africa wide solidarity and collaboration has been praised for saving the continent from the predicted fatalities **(**Tangwa & Munung 2020).

Beyond the continental initiatives, the World Health Organisation (WHO) and Africa Centre for Disease Control (CDC) have had a profound effect on the design of containment and mitigation measures. The same containment measures- social distancing, frequent hand washing and use of hand sanitizer, PPEs, lockdowns, school closures and border closures have been used across Africa and in the study countries. Similarly, common mitigation and support measures have been directed at households (i. access to basic services- water, electricity, and health; ii. social safety nets- cash transfers, food distribution and price controls, and prisoner releases; and iii. income protection- income and consumption tax reductions/suspensions. For businesses, support has consisted of low interest loans, relaxation of loan repayment requirements and tax benefits.

[45] https://www.africanews.com/2021/01/19/africa-medical-supplies-platform-amsp-opens-covid-19-vaccines-pre-orders-for-55-african-union-member-states//

Table 7: Stringency and Nature of Containment Measures

Country	Nature of Containment measures	Specific COVID-19 Containment Measures		Affected Groups	Ease/terms of compliance
Benin	**Mild** • Partial lockdown-cordon sanitaire of 15 commune in the South	**Health**	Nose mask wearing-12	All	Cost and affordability
Burkina Faso	**Drastic** • Curfew throughout the country-7pm-5am • Lockdown-Partial		Testing -12	Travellers and sick people	Cost, affordability, and access to facilities
Ethiopia	**Mild** • Partial lockdown		Social distancing-12	All	Difficult for people living and working on streets, market, and homes Income loss due to compliance
Ghana	**Mild** • Partial lockdown	**Restrictions, advisories, and restrictions**	Travel restrictions -12	Traders, commercial transport operators	Loss of income
Kenya	**Medium** • Curfew from 7pm to 5am/9pm-4am (30 days) • Partial lockdown		Curfew -7 (Burkina Faso, Mali, Nigeria, Rwanda, Kenya, Uganda, Tunisia)	All	Loss of income
Mali	**Medium** • Curfew-9pm-5am • Lockdown		Lockdown-12	Traders, informal workers	Loss of income
Mozambique	**Drastic** • State of Emergency • Curfew • Partial lockdown		Market Closure-7 Ghana, Burkina Faso, Rwanda, Benin, Ethiopia, Uganda	Traders, commercial transport operators	Loss of income
Niger	**Mild** • Curfew-Niamey-7pm-6am		Airport and border closure-12	Traders and border communities	Loss of income
Nigeria	**Medium** • Curfew-partial • Lockdown-partial		Market fumigation- 1 Ghana	Traders	Loss of income
Rwanda	**Drastic** • Nationwide total lockdown • Curfew-nationwide-9pm-5am		Limit/regulation on passengers in commercial vehicles - 12	Commercial transport owners Passengers	Loss of income
Tunisia	**Drastic** • Total lockdown • Curfew	**Education**	School closure -12	Rural students, students from poor homes	Loss of income, increase care burden on women
Uganda	**Drastic** • Nationwide lockdown • Curfew-7pm-5am	**Laws**	Laws/ decrees-12	-	-

Source: 12 Country studies (2021)[46]

The appearance of uniformity notwithstanding, a closer inspection reveals that the portfolios of country responses differ in intensity, spread and beneficiaries. For example, the beneficiaries of cash transfers have included different combinations of the following categories of persons identified as vulnerable or facing existential crises: poor women, people with chronic and degenerative diseases; children in difficulty, people living with disability, pregnant women without a source of income, women headed households, women with six or more dependents, families hosting internally displaced persons, elderly people, internally displaced/refugees, people already benefiting from basic social security policies and street residents. As well, there were measures that were used by very few countries, such as the provision of housing for homeless persons (Ethiopia and Nigeria). While food distribution was limited to specific groups of vulnerable people in various countries, Burkina Faso and Rwanda took steps to fix prices of food and other essentials to protect the population from price hikes, which had been experienced in all the study countries.
Many African countries were prompt and proactive in announcing and implementing containment measures in response to the COVID-19 outbreak. An examination of containment measures has led us to classify containment measures in terms of stringency[47]. Our table below shows that of our twelve countries, Mozambique, Rwanda, Tunisia, and Uganda put in place drastic stringency measures, Burkina Faso, Kenya, Mali, and Nigeria, put in place medium stringency measures, while Benin, Ethiopia, Ghana, and Niger put in place the mildest measures. First wave country lockdowns were on a continuum between severe and long duration lockdowns (Rwanda) and selective and shorter lockdowns (Ghana; Benin's cordon sanitaire).

The containment measures that were most common in the twelve study countries in the first wave of containment were face masks, testing for travellers and sick persons, social distancing, travel restrictions, some level of lockdowns, airport and border closures, regulation of the numbers in commercial hospitals, school closures and laws and decrees instituting punishment for non-compliance. Only seven of the twelve instituted the closure of markets (Benin, Burkina Faso, Ethiopia, Ghana, and Uganda), while only Ghana reported the fumigation of markets.

It is noteworthy that in the initial stages of the pandemic, African countries except for Tanzania took a health first approach, it became clear that the disruptions in the economy were even more devastating than the pandemic itself. Stringent measures implemented by many countries from March 2020 including lockdowns, shutdowns of some parts of the economy, curfews, border, and school closures, among others, gave way to flexibility and the prioritisation of addressing economic impacts. Thus, although the second and third waves

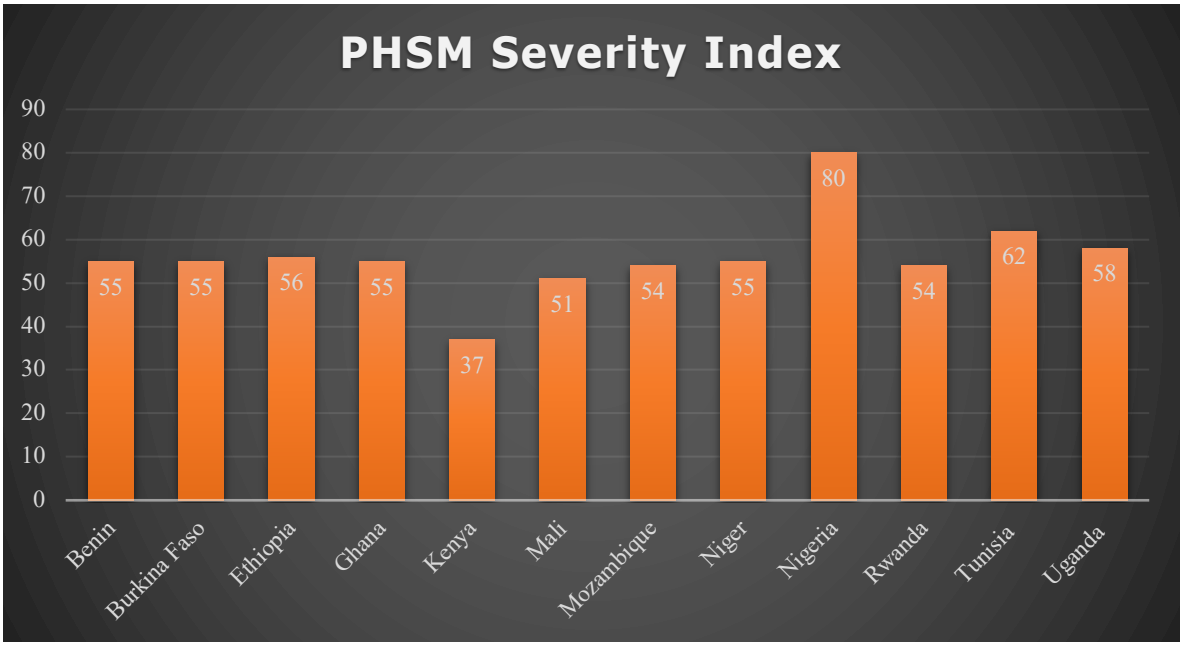
[46] Wantchekon, Leonard & Leonie Koumassa; Darkwah, Akosua, K; Hassen, Majdi, Marouani Mohamed Ali & Wojcieszynski Emilie, Laura Ferguson, Laura, Satchi, Krishni, Kizito Irene & Kuria Shiphrah; Idrissa , Abdourahmane; Nuvunga, Adriano; Collet, Angela, Machava, Agostinho & Dimas Sinoia; Obiakor, Thelma, Iheonu Chimere & Ihezi Ezra; Osei-Boateng , Clara & Vlaminck, Zjos; Pambè, Madeleine Wayack, Thorsen Dorte, Darkwah Akosua K; Teshager Kassa & Chofana Tesfaye; Traoré, Ousmane, Z & Diarra Djénéba; Ferguson, Laura, Lambert-Peck, Miles, Kapsandui, Tonny & Kuria Shiphrah, Munu, M. L. & Vlaminck, Z.

[47] Three main mobility related restrictions implemented in study countries were, lockdowns, curfews, and border closures. All 12 countries closed borders. In rating the nature of containment measures, we have considered the number and nature of the lockdown, curfew, and any other measure.

- **i)** Drastic- three or more measures implemented with nationwide /total application of the measure
- **ii)** Medium- two measures implemented
- **iii)** Mild- one measure implemented

resulted in more infections and fatalities, drastic containment measures have not been reinstituted in many countries.

Figure 2: PHSM Severity Index Score (20th July 2021)



Source: WHO, 2021

In 2021, while many countries tried to balance health and economic imperatives, Nigeria, Tunisia, Uganda, and Ethiopia imposed even more severe measures according to the WHO's Public Health and Social Measures (PHSM)[48] index has shown. The data is based on six indicators namely wearing of masks or facial coverings, restrictions on international travel, restrictions on Gatherings, adapting or closing schools, adapting, or closing offices, businesses, institutions and operations and restrictions on domestic movement (Figure 2).

While countries have been praised for their proactivity and seriousness in instituting containment measures, and Africa's low infection and mortality rates attributed to the speed and strength of containment measures (UN Committee for Development Policy, 2021), the link has not been properly established between the stringency of measures and infection/mortality rates. The picture is also complicated by shifts in the stringency of measures over time, the time between when measures are imposed and when their effects can be measured, levels of compliance, the seriousness of enforcement and types of relaxation of measures. This coupled with the weaknesses of data collection around infections and deaths mean that any such assessments must be treated with caution. The twelve studies have found that in several countries, containment measures were implemented with scant attention for human rights and human dignity, in some cases resulting in human rights abuses, particularly in relation to curfews and lockdown regulations (Rwanda, Kenya, Uganda and Nigeria).

[48] https://covid19.who.int/who-data/phsm-severity-data.csv

In almost all cases, parents and students considered school closures to be premature and too long and damaging in accentuating inequalities in access to certain kinds of e-learning media and depriving poor children of the benefits of school feeding programmes and exacerbating female rates of attrition and teenage pregnancy. Similarly, land border closures, a containment measure that has enjoyed the longest duration in most countries, have proved damaging for food prices, food security and the livelihoods of small traders and local economies who depend on cross-border economic activities.

For certain measures such as face masks and testing, the main challenges in compliance were costs and affordability, with testing having the additional challenge of access to facilities. For most other measures- travel restrictions, curfews, airport, border and market closures, lockdown, curfews, limiting passenger numbers and closure of schools, the loss of income for operators and workers was the most serious problem. In addition, school closures increased the care burden for women which increasing the risks of attrition among students in rural and poor urban areas. Social distancing has been structurally difficult to comply with for people living and working on the streets, markets, informal settlements, and housing, and has also affected their incomes in various ways.

Mitigation Measures: Challenges with Design, Targeting and Effects

In addition to containment measures, mitigation and support measures were instituted in the twelve study countries. Of the four kinds of mitigation measures adopted across the study countries, three were targeted at households (access to essential services, social safety nets and income protection) and one directed at businesses (financial support and tax reductions). Access to essential services including water and electricity subsidies, access to remote teaching facilities, and free medical care and counselling for certain groups, the provision of hygiene and personal protection equipment free of charge or at subsidised rates, recruitment of additional personnel, the construction of new health facilities and investment in research and medical innovations. Social safety net measures included the increase in amounts of cash transfers, the expansion in the numbers and categories of beneficiaries, prisoner pardons and early release and food security measures such as securing of food stocks, food distribution to vulnerable groups, food price controls and the reactivation of food security institutions.

To attenuate the effects of food inflation, the government of Benin subsidised food producers while Rwanda fixed prices for essential food items and sourced food from the national food reserves. In Niger, price ceiling was adopted for essential food items such as grains.

There were two broad types of income protection- income support in the form of special allowances and deferrals of loan obligations. Business support consisted of financial support in the form of loans and credit, regulatory relaxation such as monetary policies, lower central bank rates and cash reserve ratios for banks; and tax measures such as rebates and exemptions. All 12 countries had some version of all the four kinds of measures.

However, a few countries instituted some measures that were quite specific to them. These including in the case of access to services the institution of online payments for taxes and the acquisition of judicial records (Benin), exemptions from service fees relating to mobile banking and ATM platforms (Ghana, Mozambique and Rwanda), increases in the limit per transaction and daily transaction for mobile wallets (Mozambique),

fuel subsidy (Nigeria), subsidy for solar home system kits (Nigeria, Burkina Faso), agricultural inputs, seeds and fertilizers access through e-vouchers (Uganda), sanitation and health counselling for commercial sex workers (Ethiopia) and free distribution of cattle feed (Mali). Nigeria and Ethiopia were the only two countries with measures directed at housing. Ethiopia provided transitory shelter for urban destitute street children while Nigeria provided subsidised housing. In addition to the range of common food security measures, Ethiopia provided food provisions for commercial sex workers.

Ethiopia was the only country that instituted family reunification measures. These included the reunification of destitute and vulnerable groups with family and the integration of vulnerable returned migrants with their families. As well, Ethiopia instituted some labour rights measures. Employers were instructed not to lay-off workers in public and private companies during the declared state of emergency. There was also government monitoring of petitions from 366 labour organizations who expressed opposition to layoffs, denial of wages and pay cuts and championed the reinstatement of laid off workers. For business support, Burkina Faso had two additional measures- free parking for taxis and the suspension of rents for marketplaces.

A set of mitigation measures can be described as efforts at domestic resource mobilisation. Some of these were substantive and others symbolic. They include the renunciation of salaries of members of the government to contribute to the financing of Covid-19 prevention and mitigation measures (Burkina Faso) and the voluntary reduction in the salaries of the senior ranks of the National Executive (Kenya). Others were efforts to mobilise funds to support particular groups. For example, Bureaus of Labour and Social Affairs (BOLSA) in collaboration with the Ethiopian Federation of National Associations of Persons with Disabilities mobilized funds from development partners to provide food and sanitation assistance to its members (Ethiopia). There were also the “Sharing food with helpless neighbours” and "Our Health is in Our Hands" campaigns (Ethiopia), the construction of a 100-bed health facility in Accra by the private sector, with promises to construct two more facilities in Kumasi and Tamale, the three most populous cities in the country (Darkwah, 2021).

Taxation was a particularly fertile ground for interventions. In all twelve countries, there were exemptions on capital gains, consumption taxes of different kinds and income tax rebates and tax reliefs. There were also measures to reduce and ease customs duties in several countries. Only Ethiopia and Ghana had a waiver on gifts and charitable donations in support of COVID-19; while Ethiopia also had an amnesty and forgiveness of tax debts. All countries instituted measures to improve and ease tax services. Niger suspended prosecutions for tax recoveries, while four countries- Burkina Faso, Ethiopia, Ghana, and Tunisia, either cancelled, suspended, reduced, or waived penalties and fines. Burkina Faso and Niger reduced licence fees for businesses in COVID-19 hit industries such as passenger transport, hotels, and tourism.

Mitigation and stimulus measures, though welcomed by citizens, have been mainly short-term, poorly targeted and implemented, and biased against the rural and urban informal economy. This is even though for most of the study countries, the informal economy is larger by far than the formal. Situating the implications of COVID-19 responses within existing structural inequalities between rural and urban, formal, and informal economies, women, and men, between geographic regions, and rich and poor, it becomes clear that the implementation of COVID-19 measures created new forms of inequalities and a new poor.

An examination of interventions reveals the following:

i. Tackling poverty does not necessarily address inequalities. Inequalities require measures that respond to the structural basis of inequalities, and not to immediate pandemic effects.
ii. The criteria and modalities for accessing interventions excluded the poorest of the poor.
iii. The measures were short-term, directed at addressing poverty and vulnerability, while ignoring pre-existing structural inequalities- regional, rural urban, income, gender, and disability. As a result, beneficiaries of both economic and social protection measures were only a minuscule proportion of those suffering dislocation and the opportunity to address inequalities was lost. For example, the Mozambique study concluded that addressing the challenges of transportation would have done more for the poor than some of the measures in place. Secondly, the Tunisia study found that those just above the poverty line probably became worse-off because they did not get any support at all
iv. While many of the support measures were temporary, some restrictive measures instituted through the passage of new laws may endure. Many of the laws and decrees were hurriedly passed and controversial, and there are fears that post-COVID-19, they could continue to be used to repress citizens. In some cases, governments targeted measures at specific groups- cattle feed for farmers in Mali, tax waivers for health workers in Ghana, medical care, and counselling for people with disability and addictions and the reintegration of returned migrants with their families in Ethiopia, and the provision of free water in public standpipes in urban areas in Burkina Faso. In several countries, vulnerable families received food parcels and cash transfers, middle class households enjoyed free utilities and companies in the formal sector received tax reductions and cuts. There were also differences in attention to rural and urban areas in several countries.[49]
v. In all case study countries, food programmes for vulnerable groups remained inadequate and did not reach many of the old and new food insecure. While programmes targeted nationals and urban based people generally, as well as some of the food insecure groups, including female headed households, lactating mothers, and urban poor were targeted, refugees, vulnerable immigrants, and the new poor were often excluded from the measures.
vi. In Ghana, food supply to vulnerable urban dwellers only lasted in the lockdown period and targeted only a few vulnerable urban dwellers. In Uganda, the government food programme for sex workers was limited to only one district and only vulnerable Ugandans with citizenship identity cards qualified for access to food support. The lack of accountability in food distribution programmes in Ghana, Kenya, Uganda, and other countries raised the issues of government officials benefiting from a crisis.
vii. Access to subsidies for water and electricity for households required both availability and access to supply infrastructure. In several countries, this meant that particular regions, rural and poor urban areas, households that did not benefit. While Burkina Faso (rural water supply) and Kenya

[49] The Burkina Faso report for example, notes, “two weeks after the decrees restricting people's mobility and activities, the government announced a series of measures to mitigate the impact of these measures on people's living conditions. These concerned economic sector actors and people working in markets, as well as categories of people identified as vulnerable. A battery of fiscal measures were taken in favour of businesses. Measures were also taken by the government to secure stocks of consumer goods (sugar, milk, rice, oil, soap, etc.) and to guarantee the availability of stocks, with a strengthening of the mechanisms to combat clandestine storage and price control throughout the country. The government took over the operating costs of the people working in the markets. For the rest of the population, subsidies were made for access to basic services, namely water and electricity. These measures mainly concerned urban populations, even though in the authorities’ speeches it was regularly recalled that the rural environment "was not forgotten". The actions favouring the categories of population identified as particularly vulnerable… consisted mainly of food distributions and, for the most deprived, cash transfers over three months” (Pambè, Wayack & Darkwah, 2021, pp. 1)

(urban slum water supply) tried corrective measures, these were largely unsuccessful due to operational difficulties. Thus, the main beneficiaries of utility subsidies were urban and middle-class families who had their own water and electricity metres.

viii. Access to business stimulus packages depended on the level of formalisation of businesses, namely registration, formal tax payment records and possession of tax identification numbers. These conditions excluded already vulnerable businesses such as small traders and those with little or no formal education.

Measures targeted at the poor and vulnerable mostly built on already existing cash-transfer schemes. Most countries (except Tunisia) have few programmes that cover a wide range of social groups. COVID-19 measures laid bare the limitations of existing social protection measures such as cash transfers for the poor. COVID-19 provided the opportunity for the expansion of social protection programmes in all countries and highlighted the need to support forgotten populations. Some countries tried to increase eligible numbers (Nigeria expanded its national social register, and Ethiopia, Mozambique, Uganda, and Tunisia either increased coverage or applied the same programme to new beneficiaries). Others only improved what was being offered to already existing beneficiaries (Ghana). In the main, existing social protection regimes which formed the basis of government responses to COVID-19 have been too limited and inadequate to effectively address the toll of the pandemic on populations.

The mixed results of targeting measures have raised concerns about the deepening of structural inequalities of class, gender, ethnicity, race, and geography (between francophones and others- Mali; against those just above the poverty line (Tunisia); against itinerant workers (Rwanda); against certain regions (northern Ghana), rural and informal workers, and women (All countries).
In spite of the inclusion of women and female headed households among the beneficiaries of cash transfers, COVID-19 response measures largely ignored the gender dimensions of the pandemic, and more specifically, the impacts on the subsistence and care economies where the daily and generational reproduction of working people takes place, particularly in those economies in which work is largely informal and precarious and in which reproductive work is time-consuming and without adequate support in terms of access to critical social services (Ossome, 2021).

Urban areas were privileged in COVID-19 responses because they were identified as the hardest hit. Even within urban privilege, much of the support went to the formal economic sectors although the hardest hit was the urban informal economy. Only a few of the twelve study countries supported agriculture, and by implication, rural households. Mali's cattle feed subsidy is a good example as are the measures to support the acquisition of agricultural inputs and livestock feed for agricultural enterprises (Ghana, Burkina Faso, Mali, Rwanda, and Uganda).

Several worrying political trends which predated the pandemic are becoming even more entrenched. One of these is the decline of democracy (Protect Democracy and Stand-UP Ideas, 2018) In an analysis of politics during the pandemic, the rise of populist nationalism has been flagged.[50] While populist leaders are not limited to any one context, it is noteworthy that some of their attributes and actions are present in responses

[50] Populist nationalism combines nationalism (turning states inwards and prioritising national interests over global interests) and populism, which is built on division, pitting the people against the elite, the scapegoating of foreigners, attacks on science and the manipulation of infection figures, vaccine nationalism, human rights violations, making political capital out of COVID-19 responses, the dismantling of social safety nets and deepening of austerity; racism, xenophobia and homophobia (Williams *et al*, 2020).

of some of Africa's political leaders, including those not classified as populist, before and after the start of the pandemic.

Furthermore, studies of two past epidemics of the 20th Century- the Bubonic plague and Spanish Influenza, found that there was a heightened risk of the use of public health action to entrench oppressive governance policies in in pre-apartheid South Africa. Thus, the conclusion that public health crises engender oppressive social, economic, and spatial transformations (Finn and Kobayashi, 2020) should concern.

Beyond our study countries, studies have found that the handling of the pandemic heightened citizens' mistrust of governments in some African countries. The altercations between states and their vulnerable populations, as well as the excesses of some of the measures, epitomize a state fighting the poor, not COVID-19[51]. The shutting down of workplaces without adequate welfare and protection and physical harassment of people trading and sleeping on the streets are indications of the African state's inability to fulfil its social contract as a guarantor of decent work and housing. The struggles of the poor to remain on the streets even at the peril of their lives, is a strong statement about claims to substantive citizenship. It is also a demand for the necessities that can ameliorate the effects of COVID-19.

The enforcement of COVID-19 containment and preventive measures have been blamed for the escalation in human rights abuses. Repressive measures have ranged from the clampdown on protests and demonstrations such as those observed in Zimbabwe to military and police high handedness that resulted in deaths in Ghana, Nigeria, Kenya, Guinea, and South Africa. In general, COVID-19 intensified and entrenched repressive regimes and made more visible the inequalities that exist in countries and the lack of proper social policies to address them. Some commentators believed that the virus was being used by some African governments as a cover for wider repression. As will become clear in the next section, this issue emerged as an important element of the work of civil society organisations.

CSOs in the time of the Pandemic: Necessary but not always recognised or welcome.

It is evident from the literature and from our twelve studies that civil society and CSOs (NGOs, community organisations, associations, trades unions and workers associations, faith-based organisations and other spontaneous and loose formations and indvidual actors) were important players in the COVID-19 responses. As the Mozambique report notes, the role of CSOs has been crucial, given that the Government has shown limited capacity to protect the vulnerable population (Nuvunga, Collet, Machava, Agostinho & Dimas, 2021). The Nigeria study notes:

> *CSOs impacted the lives of individuals and communities experiencing the effects of the pandemic and the policy measures taken by the government to curb its spread. Across Nigeria, CSOs worked as defenders of human rights and frontline responders, ensuring transparency from the government, and*

[51] https://borgenproject.org/the-impact-of-covid-19-on-poverty-in-ghana

> *providing food and hygiene products for vulnerable people… CSOs also intervened, focusing on mitigating the impact of the government's lockdown and restriction policies and plugging holes in the government's responses (Obiakor, Iheonu & Ihezi, 2021, pp:31).*

Similarly, the Ethiopia study found that civil society organizations provided a significant resource and money and engaged in awareness creation and provided training to health workers (Teshager & Chofana, 2021). The Ghana study however found that CSO responses were less important to Ghanaians. While CSOs/ NGOs (both local and international) responded to COVID-19, the Ghana Statistical Service (GSS) Household and Job Tracker (2020) noted that support from NGOs was indicated as the least common coping mechanism (1.3%) (Osei-Boateng , & Vlaminck 2021). This is not surprising because the state took centre stage and also because of the specific character of CSO involvements, their more limited reach, and the fact that existing CSOs largely extended their work into addressing COVID-19 issues. Therefore, they were not uniformly active in all countries.

CSO involvement, visibility, effectiveness, and room for manoeuvre also depended on the robustness of the civic space, the development of the sector prior to COVID-19 and government perceptions about who was needed at the table. The Kenya study notes that differences in the levels of CSO involvement in the pandemic response also speaks to the heterogeneity of their roles. The study found that public health CSOs were seen to have larger roles compared with those involved in areas such as rights or poverty alleviation. This had implications for CSO inclusion in discussions about COVID-19 policies. Thus, human rights organizations, which were not seen to be directly involved, were not invited to the table in some countries. This, according to the Kenya study, highlights the problem of considering civil society as a single stakeholder. Participation of different constituents within civil society is critical (Ferguson, Satchi, Kizito & Kuria, 2021).

CSO contributions to the COVID-19 containment and mitigation effort were at different levels, from the national to the local. The various country studies discuss CSO involvement in more or less detail and therefore the information is uneven. However, some patterns emerge which enable a discussion of the importance of CSO involvement, some of the common activities of CSOs as well as the more specific activities, CSO achievements and the challenges they encountered in their contribution to the COVID-19 response.

Four Areas of CSO Activities

There were minor differences in the classification of areas of CSO involvement among the study countries. However, the activities identified fall within the four broad areas examined in the Nigeria study - a) monitoring responses and defending citizens from human rights abuses, b) demanding accountability and transparency in government spending decisions; c) disseminating information and curbing misinformation, and d) delivering services and providing palliatives (Obiakor, Iheonu & Ihezi, 2021). It is important to point out that some of the CSOs combined two or more such activities, as they did before COVID-19, or in some cases, took up short-term additional areas of work, especially relief work. For all these activities, it has been pointed out that CSOs mobilized resources from domestic and foreign sources (Pambè, Wayack & Darkwah, 2021).

In terms of monitoring and defending human rights abuse, the Nigeria study provides the most examples. Spaces for Change (S4C), one of Nigeria's top civic space defenders, led a countrywide effort to monitor,

document and analyse the government's response to the pandemic. The organization also launched a series of initiatives intended to curtail government repression and safeguard the rights and work of human rights defenders. It also engaged in legal representation, petitioning agencies responsible for addressing human rights violations and a communications campaign to share important health information and international advocacy. Other organisations working in that space were Citizen's gavel, a civic-tech organization and the Legal Defence and Assistance Project (LEDAP) (Obiakor, Iheonu & Ihezi, 2021). In Kenya, the Independent Medical Legal Unit, Amnesty International, International Commission of Jurists Kenya (ICJ Kenya) and Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN) were working on issues of police accountability through a range of activities including providing legal advice to vulnerable populations and public interest litigation. For example, Amnesty International Kenya, Haki Africa, Kituo Cha Sheria, International Justice Mission Kenya brought a lawsuit against the police, alleging that they were using the night-time curfew to violate people's rights and carrying out killings (Ferguson, Satchi, Kizito & Kuria, 2021).

The work on demanding accountability and transparency and advocacy for policy change was an important area of CSO endeavour. As the Ghana study observed, the majority of CSOs specialise in advocacy for good governance, improved services and social justice (Osei-Boateng & Vlaminck 2021) In Mozambique, the Budget Monitoring Forum (FMO), Civil Society Social Protection Platform (PSCM-PS) and Women's Forum/human rights NGOs monitored the implementation of the COVID-19 Plans in various sectors and carried out equity-related advocacy campaigns and research to assert that the main focus of all efforts should be to target the policies to the most vulnerable population groups that were likely to suffer the greatest negative impact of the pandemic and pandemic responses (Nuvunga, Collet, Machava, Agostinho & Dimas, 2021). In Nigeria, Connected Development, a grassroots organisation focused on strengthening citizens' capacities to hold the government accountable, using their social accountability platform, ifollow.money.org, to track and provide information on the status and spending of donations made toward the fight against COVID-19. Other organisations doing similar work in Nigeria were the Socio-economic Rights and Accountability Project (SERAP), Network for Health Equity and Development (NHED) as well as the Women's Rights Advancement and Protection Alternative (WRAPA), which worked with a coalition of other women's rights organisations and the Ministry of Women's Affairs to educate the public, demand basic needs, and protect women and children from abuse (Obiakor, Iheonu & Ihezi, 2021).

In Burkina Faso, CSOs questioned the need for nationwide measures such as lockdown, given the economic realities of the country and the likely impacts on incomes. The Syndicat national des artistes musiciens du Burkina (SYNAMUB) denounced the clannish management of funds allocated to cultural and tourist actors. The Coalition Against the High Cost of Living (CCVC) described the management of the pandemic in Burkina Faso as "haphazard" and made up of "trial and error", with the aim of organising the plundering of the country's wealth. Another party, Soleil d'Avenir, questioned the government on the disastrous results of its management of the pandemic (Pambè, Wayack & Darkwah, 2021).

In Ghana, several CSOs monitored the government's response, provided feedback, and used the evidence to hold government to account. In July 2020, the CSO Platform completed two rounds of survey to assess citizens' perception of Government's response to COVID-19 and shared the findings widely with stakeholders including government and the media. The West Africa Civil Society Institute (WACSI) held a webinar in August 2020 to discuss government's disbursement and (mis)management of COVID-19 funds; examine

notable gaps in accountability, transparency, and leadership oversight, as well as explore strategies to strengthen fiscal accountability systems and mechanisms (Osei-Boateng , Clara & Vlaminck 2021).).

The work on disseminating information and curbing misinformation is an area of work which was in some cases a recent addition to CSO work. An overlooked challenge was the spread of misinformation about COVID-19, what has been described as an infodemic. CSOs working in this area disseminated health information and countered misinformation in several of the study countries. In Nigeria, key CSOs in this area were the Centre for Democracy and Development (CDD) and the Akin Fadeyi Foundation which worked in English and widely spoken local languages in Nigeria (Obiakor, Iheonu & Ihezi, 2021).

In Ghana, local CSOs/NGOs/trade unions in partnership with international organisations such as development partners and international NGOs (INGOs) designed Information, Communication and Educational (IEC) materials such as brochures, flyers and posters and disseminated information on COVID-19 protocols. They also partnered with state institutions such as the Ghana Health Service (GHS), National Council for Civic Education (NCCE) and district assemblies as well as among themselves to sensitise the public through information dissemination outlets such as radio, television and information vans. Most of the interventions were directed at vulnerable groups most affected by the pandemic such as elderly people, PWDs, *Kayayei* and slum communities. For example, the Ghana Federation of Disability Organisations (GFDO) partnered with the Christian Health Association of Ghana (CHAG), network of faith-based health service providers and Ghana Health Service to design disability friendly health promotion materials. The GFDO also lobbied the Ministry of Health and the Ministry of Information to include sign language during Press Briefings. Some CSOs (e.g., ActionAid) embedded messages about gender-based violence to raise awareness and publicise helplines. The STAR-Ghana Foundation (with funding from the UK and EU) between April and August, funded eight (8) CSOs with direct reach of 638,956 and eight million through the media (Osei-Boateng & Vlaminck 2021).

CSOs in Burkina Faso contributed to public health by producing and disseminating the guide "Conduct in gynaecology and obstetrics and neonatology during the period of the corona virus infection pandemic in Burkina Faso", drawn up by the Society of Gynecologists and Obstetricians in Burkina Faso (SOGOB), the Burkinabè Pediatric Society (SOBUPED), the Mother-Child Network in the Hauts Bassins region (REMEHBS) and the Burkinabè Association of Midwives (ABSFM) (Pambè, Wayack & Darkwah, 2021).

Service delivery and the provision of palliatives to vulnerable communities was initially the most common activity of a range of CSOs in the early stages of the pandemic. In Nigeria, both CSOs and loose groups of private citizens offered food, sanitary products, and other essentials to people in need (Obiakor, Iheonu & Ihezi, 2021). In Mozambique, while CSOs were not invited to participate in the high-level advisory committee, they were strongly involved in the implementation of the social protection Response Plan to COVID-19. CSO tasks included monitoring and identifying potential beneficiaries so that they could be enrolled in the PASD-PE “COVID-19”; and channelling possible complaints and claims by beneficiaries for the effective implementation of the Response Plan (Nuvunga, Collet, Machava, Agostinho & Dimas, 2021). CSOs in Ghana also provided directly or coordinated relief items for the poor and vulnerable. For instance, the *Kayayei* Association of Ghana (KAG) reported collaboration with ORA Foundation and others to provide dry food packs and facemasks to *Kayayei*. CARITAS Ghana raised almost GHS2 million to support 180,000 vulnerable people with food, PPEs, and temporary shelter. Other CSOs that provided direct relief to citizens

include Action Aid Ghana, CSO Platform on SDGs and Catholic Relief Services (CRS) among others (Osei-Boateng & Vlaminck 2021)

Achieving Results in Challenging Circumstances

In spite of the general finding in the country studies that Civil society and CSOs were not involved in defining the responses to the pandemic, several reports concluded that CSOs had made a difference. For example, it has been argued that CSOs succeeded in forcing goverments to change course and take actions that somewhat mitigated the negative impacts of initial responses. In some study countries such as Burkina Faso and Nigeria, the management of the pandemic has been accompanied by ongoing challenges to public authority and pressure from civil society, opposition political parties and various trades unions to encourage the government to take appropriate measures. In Burkina Faso, the lifting of containment measures such as curfews and the closure of shops and restaurants followed demonstrations by the population. Similarly, there were regular protests in social networks. In Nigeria, the disbanding of SARs, the feared elite anti-crime police unit is a good example of civil society campaigns (Pambè, Wayack & Darkwah, 2021; Iheonu & Ihezi, 2021).

As the Burkina Faso study argues, although in some cases spontaneous and unco-ordinated, these actions by civil society enhanced the inclusivity of Covid-19 responses by successfully demanding policy changes that addressed the plight of certain vulnerable population groups. These included displaced persons, people living with a disability, street children, children in orphanages and reception centres, pregnant women and newborn babies, women in charge of public health, and migrants (Pambè, Wayack & Darkwah, 2021).

These successes notwithstanding, CSOs had to grapple with challenges such as the openness of the political culture and the failure of governments to recognize and facilitate their contributions. The Uganda study found that while CSOs provided many of Uganda's reproductive and psychosocial services, they were not designated as essential service providers, and therefore did not receive special travel permits. This limited their effectiveness as access to their services was limited (Ferguson, Lambert-Peck, Kapsandui & Kuria, 2021).

The Rwanda report for its part found that high levels of government control restricted the implementation of solidarity initiatives by individuals and CSOs. For example, journalists who wanted to give support in an informal settlement were arrested. On the other hand, trade unions and workers' associations such as taxi-moto or taxi-velo associations were consulted on how measures could be effectively enforced. Even those organisations that were consulted such as trade unions and workers' associations, had little room to critically question the government's decisions seems. These findings point to the selective treatment of the CSO sector discussed earlier in this synthesis report. It appears that in Rwanda, CSOs are tolerated if they play a constructive (non-critical) role (Munu & Vlaminck, 2021). Similarly, the Mozambique report found that a key challenge to CSO effectiveness was their absence from the multi-sectoral Technical and Scientific Commission created to advise the Government on COVID-19 response policies and measures (Nuvunga, Collet, Machava, Agostinho & Dimas, 2021). Another barrier to CSO effectiveness in supporting the implementation of policies to respond to COVID-19 was the lack of access to information on the Government Plan and its benefits to vulnerable groups (Nuvunga, Collet, Machava, Agostinho & Dimas, 2021).

In contrast with the more restrictive approach to CSOs in Rwanda and Mozambique, the government of Burkina Faso utilised stakeholder consultations to reassure the citizenry about its good governance approach

to the management of the pandemic and gain public support. For example, the Ministry of Health met with the national anti-corruption network (RENLAC) to discuss and reassure about the proper use of the resources mobilised for the management of Covid-19. As well, the government met with political parties from the majority and the opposition to promote support for a concerted and efficient management of the pandemic. At the same time, a national committee for the crisis management of the pandemic was created, made up of government representatives, technical and financial partners working in the health sector, representatives of private health structures and civil society. The High Council for Social Dialogue also initiated a framework bringing together members of the government, employers and workers with the aim of encouraging joint reflection on the socio-economic consequences of the pandemic, the development of palliative measures acceptable to the population and the potential impact of measures to suspend biometric enrolment the issuing of national identity cards on the electoral agenda (Pambè, Wayack & Darkwah, 2021).

Some studies have also differentiated between the treatment of local/national CSOs and international donors. In Rwanda for example, while local CSOS were not involved in policy formulation processes of COVID-19 prevention and mitigation but were consulted later to share ideas on how to reactivate certain sectors in a COVID-19-safe way, international donors such as UNDP played key roles in developing the government's responses to COVID-19. As noted in the Rwanda report, "The current governance approach supports a culture of upward accountability towards international donors rather than downward accountability towards local civil society and citizens" (Munu & Vlaminck, 2021). These challenges in the interactions between state and CSO activities influenced popular responses to COVID-19.

5. Responses to COVID-19 measures: Between Compliance and Protests

Popular responses to COVID-19 impacts and government responses ranged on a wide spectrum between full compliance and protests. Seven of the twelve country studies- Mali, Niger, Rwanda, Burkina Faso, Kenya, Uganda, and Kenya examined the issue of compliance with COVID-19 measures from a variety of angles. These include levels of compliance, who are least able to comply as well as the factors driving compliance and non-compliance. Measuring compliance is tricky, and while compliance surveys basically record what people say they do, and not their actual practice, they are a useful indication of attitudes towards containment measures and how these could influence compliance and non-compliance. In several of the countries, there were generally high levels of compliance with containment measures. Rwanda, Mali, and Niger are good cases in point. In Mali for example, the INSTAT survey (June 2020) found that most respondents reported that they complied[52] with the preventive measures taken by Malian government in response to COVID-19, 88.6% of households washed their hands more often than usual, 61.7% of them reduced their use of places of worship, while 12.9% respected all the requirements of social distancing.

Compliance even if adjudged high or low for a country is not uniform across board. In the case of Kenya, (Ferguson, Satchi, Kizito, & Kuria, 2021). compliance is adjudged to have varied widely for a variety of reasons. There were several factors identified as influencing levels of compliance. The Kenya study found that non-compliance in some cases was linked to measures deemed not to make biomedical sense, for example, the requirement that motorists wear a mask while driving alone in a car. On the other hand, people

[52] This is not an effective behaviour but what people say they do.

complied if they believed in the public health measures or wanted to avoid sanctions (Ferguson, Satchi, Kizito, & Kuria, 2021). Another incentive for compliance was when containment measures are combined with effective support measures. In the case of Mali, transportation sector actors adopted guidelines to prevent the spread of COVID-19 while complying with the measures announced by the government. The government, working through the CMTR (the road hauliers council of Mali), provided hauliers with equipment allowing them to comply with hygiene and other measures (hand washing kits and masks). As well, a COVID-19 fund was established to help businesses hard hit by the curfew and the closing of borders. The intended beneficiaries were members of the transport companies' union (SET), and particularly vulnerable workers who have lost their jobs or are working less (Traoré & Diarra, 2021).

On the other hand, measures judged to be unprecedented, draconian against religious beliefs faced an uphill task in gaining acceptance. A case in point was the closure of mosques in Niger, a Muslim majority country (Idrissa, 2021). Despite the government's collaboration with the influential Islamic Association of Niger (AIN), the directive to close mosques was flouted by many, and most mosques remained open during the pandemic. Even more important, there were violent confrontations between security agencies and youth protesting the mosque closure directives. This is despite the positioning of AIN as a liaison between the government and the faithful. AIN did not generally question the government's measures, undertaking instead to explain them to the Muslim community. In the particular case, AIN officials presented the mosque closures as a decision which the government took on their advice, even though there were no written government order decreeing mosque closures. Instead, the instruction came in the form of a communiqué read by AIN's spokesperson. Additional factors which hampered compliance included the divisions among Muslim associations that resulted in the faithful receiving contradictory or no advice about compliance. There was also scepticism among the faithful about whether there was really a pandemic that was dangerous for black people. It was also considered a contradiction that markets were allowed to remain open, while mosques were being asked to close. Respondents reportedly asked, "why the markets are open, when mosques, which open for only a few minutes at a time are closed". The Niger study (Idrissa,2021) also found that compliance was undermined by the fact the measure was unprecedented and an imposition; and, because it could not be established that the disease was so dangerous as to warrant such a drastic measure. This was compounded by a sense that government action was being dictated by the anti-Islamic West, and not founded in the concerns of the faithful citizenry. In Uganda, a study also found that some faith groups have contributed to a lack of willingness to self-isolate or adopt other preventive behaviours such as wearing a facemask, with implications for community transmission (Echoru et al., 2020).

The lack of consultation was cited as an important factor in undermining compliance. As the Kenya study suggests, "an inclusive planning team that includes stakeholders beyond the biomedical sphere and is open to criticism and sufficiently agile to adapt the response as new data emerges might help promote a more sustainable response" (Ferguson, Satchi, Kizito & Kuria, 2021)

In Niger, it was felt that a discussion with all clerics, not just those aligned with government would have led to the adoption of the best measures. In other cases, the lack of consultation was said to have resulted in decisions that did not sufficiently consider the challenges with compliance because of economic difficulties that could arise from compliance (Iddrissa, 2021).

A commonly offered reason for non-compliance was economic, that people could either not afford equipment such as face masks or hand sanitizer (Kenya), or they would starve if they did (Rwanda) (Ferguson, Satchi, Kizito & Kuria, 2021; Munu & Vlaminck, 2021). In Uganda, respondents reported that quarantine simply was not feasible for them due to food insecurity, which was particularly acute for people working in the informal sector, many of whom rely on their daily income to purchase food for their household. The Uganda government initially did not cover the costs of quarantine, thus further exacerbating people's challenges to follow this directive. After public outcry, the government agreed to cover the entire cost (Ferguson, Lambert-Peck, Miles, Kapsandui & Kuria 2021). Although the Nigeria study found that there was compliance, it also concluded that the lack of adequate support and lack of adequate consultation affected compliance. As the study noted,

> *the complete lockdown implemented in the four states without adequate notice or support, unfortunately, pushed several vulnerable populations, mostly informal sector workers, into violating lockdown rules. When developing the corresponding mitigation responses to reduce the lockdown's impact, the government did not consult with adequate stakeholders to ensure that the mitigation responses would reach the people that would be most affected* Obiakor, Iheonu & Ihezi, 2021: pp *32-33).*

In the case of teachers being required to teach online in Nigeria, for example, the lack of due diligence was noted as a problem.

> *If the government had done the required due diligence before implementing the mitigation strategies, they would have learned that teachers were ill-prepared to deal with distance learning challenges (pp:33).*

Forty-three per cent of the teachers interviewed reported that they did not engage in any form of teaching during the school closures. Only 4 per cent of the teachers said they had utilised high tech devices to deliver learning during the school closures. Over half of the teachers said they lacked access to the required tools or adequate infrastructure to facilitate distance learning. Eighty-nine per cent of the teachers said that they had not had proper training on incorporating technology into their classrooms before the pandemic, and 64 per cent mentioned that they didn't receive any training support during the school closures.

Mistrust of government was another important factor in non-compliance, and this was related to past events and the way they were handled. The Niger study (Idrissa, 2021) found that during a recent cholera outbreak, the only measure taken was to forbid street sellers from selling vegetables. This was making people sceptical about the purpose of containment measures and the extent to which they were in the interest of Nigeriens.

The lack of consultation did not always result in widespread non-compliance. Rwanda is a case in point (Munu & Vlaminck, 2021). Most people followed regulations and among those vulnerable people interviewed, there was respect for the government approach which was deemed as necessary. High levels of compliance can also be embedded in a country's political culture. In the case of Rwanda, the culture is informed by the values of togetherness and joint-responsibility because of the post-genocide nation-building discourse. As a

result, citizens are wary of publicly showing discontent. Unlike in Niger (Idrissa,2021), where there was scepticism about the seriousness of the virus, Rwanda forged compliance using war terminologies to instil fear of the virus, which was described as a sniper that could not be seen. In Rwanda, 70% of respondents in the RECOVR survey (IPA, 2020) say their household is at risk of contracting COVID-19.

The draconian approach to compliance in Rwanda (Munu & Vlaminck, 2021), has revealed that those arrested for non-compliance were mainly people who needed to circumvent restrictions to survive. For example, social distancing in informal settlements, restrictions on movement between regions could not be respected by people whose livelihoods depended on moving between city and village. Thus, even in contexts of high compliance, there are hidden actions of non-compliance. As a respondent in Rwanda noted, "*some people walked for days, hiding from the authorities in the bush to travel back to their homes*" (pp:16).

Compliance, no matter how high, initially, cannot be sustained without the participation of society in the design, implementation, monitoring and evaluation of measures. Another important factor in sustainability is the length of time of institution of measures, particularly for those that need adjustments to comply. It was pointed out that people were already tired of the measures that were in place, and this and the lack of trust in government was negatively impacting their willingness to comply as the Kenya study (Ferguson, Satchi, Kizito & Kuria, 2021) has shown.

Protests

That the handling of the COVID-19 pandemic by government has been mixed in success is evidenced by the numbers of complaints and protests from different quarters in all the twelve countries of study. While most protests registered in our studies and the media are a direct response to the handling of the pandemic, there are some that were triggered by the pandemic, though related to pre-existing governance crises. With respect to the COVID-19 protests, four kinds of protests are identifiable. The first concerns health workers protesting the inadequacy or theft of COVID-19 protective equipment (Kenya in August 2020; December 2020; Mozambique, 2020). In Ghana, the Ghana Medical Association issued several warnings and criticisms of the government and ruling party officials for flouting COVID-19 protocols and risking outbreaks. A second group protests are linked with the restrictive effects of COVID-19 responses on particular social groups. In Burkina Faso, secondary school students staged a 48-hour protest over educational reforms and COVID-19 restrictions. In Mozambique, motorcycle taxi drivers clashed with police over the enforcement of social distancing rules, while in Niger, Muslims protested over the closure of mosques in urban areas. In Rwanda, refugees and migrants who had been relocated from Libya protested lockdown provisions. Across Africa, market women in overcrowded open-air markets have been expressing their anger about having their livelihoods disrupted by a disease brought into Africa by the travelling classes.

Table 14: COVID-19 Related Protests

Direct Covid 19 Protests		Indirect COVID 19 Protests	
1. Health workers protesting the inadequacy or theft of COVID-19 protective equipment and government officials and public flouting COVID-19 rules.	• Kenya- August 2020; December 2020. • Mozambique- 2020. • Ghana- GMA statements- June 2020 to February 2021.	Volatile Civil war situation. Immediate trigger was death of a child.	• Ethiopia, 11th June 2020 protests demanding the resignation of a Regional President. •
2. Protests over the socio-economic effects of COVID-19 restrictions on particular social groups.	• Burkina Faso-secondary school students. Mozambique- motorcycle taxi drivers. • Niger- Muslims Rwanda- refugees and migrants. • Across Africa- market women	Protests about special unit police brutalities triggered by brutal policing of COVID-19 curfews.	• Nigeria, end SARS campaign.
3. Generalised protests and movements against government handling of the pandemic.	• Benin • Mali • Uganda	General hardships and volatility since the Arab Spring.	Tunisia- 1100 protests between March and June 2020.

Source: Constructed from country reports and media reports

A third category of protest concerns generalised protests and movements against government handling of the pandemic in Benin and Mali, where protestors demanded the resignation of the President. In protests about the slow distribution of food and other relief goods to vulnerable people affected by coronavirus-related restrictions in Uganda, protesters urged the government to revise anti-coronavirus measures that have benefitted the rich and "created an apartheid state and occasioned avoidable suffering upon many vulnerable Ugandans, especially women and low-income earners." Their petition also called for food distribution for those in need and free face masks for everyone, as well as for the release of political prisoners and those held for violating measures meant to contain COVID-19.[53] Similarly, there was an online petition to the IMF to cancel a three-year financing package to support the COVID-19 response in Kenya in April 2021.

The protests that have been indirectly connected to COVID-19 effects and responses have tended to be even more serious because of pre-existing crises. In Ethiopia, which is facing widespread civil conflicts, on 11th June 2020, protests in the cities of Kebri Dahar and Jijiga in the Somali Region of Ethiopia with protestors demanding that Regional President Mustafa Cagjar step down. The protests were triggered by the death of a child after lack of assistance from the regional government.[54]

In Nigeria, during the COVID-19 phase 1 lockdown, increased reports of brutality by security operatives resulted in 18 known fatalities. As the lockdown eased into curfews, tensions created by the deaths, and the enforcement of curfews by security officials resulted in renewed calls for police accountability in Nigeria. In

[53] https://www.aljazeera.com/news/2020/5/19/uganda-arrests-stella-nyanzi-at-protest-over-coronavirus-response
[54] https://monitor.civicus.org/updates/2020/08/20/hundreds-dead-after-protests-fears-over-covid-19-restrictions-impact-free-speech/

October 2020, peaceful protests known as the #EndSARS campaign, demanded that the government dissolve the SARS, the Special Anti-Robbery Squad, a branch of the Nigeria Police Force. Unfortunately, the protests culminated in the death of at least 45 people across Nigeria at the hands of security officials. Tunisia also experienced what has been described as 1100 protests between March and June 2020. It has been observed that the increase in the number of protests[55] reflected the extreme circumstances faced by groups in need. In June 2020, there was an 81% increase in the number of demonstrations. Between February and December 2020, most of the demonstrations were of public sector workers. The demonstrations, which were heaviest in the regions with the highest levels of poverty and disrupted services, were driven by socio-economic factors including access to education and other services, issues that were present before the pandemic, but had been exacerbated during the pandemic.

6. Inventions, initiatives, and innovations: Opportunities and Challenges

The pandemic presented opportunities for innovations across the continent. In addition to the widespread adoption of e-solutions and inventions that are detailed below, there were some initiatives which grabbed the headlines in Africa. One of these was the return to African medicines and preventive measures such as the promotion and increased consumption of indigenous food and spices. As news of the launch of the Madagascar COVID Organics (CVO), made from the artemisia plant circulated widely across the world, citizens in some African countries called on their governments to secure supplies. The plant's antimalarial properties and its promotion by the Madagascar president, who drunk it openly, gave some legitimacy to the product. In Cameroon, a Catholic Bishop, Archbishop Samuel Kleda, announced two herbal medicines- "Elixir Covid" and "Adsak Covid," for treating COVID-19 infections.[56] The medications were distributed to patients in Catholic health centres in Cameroon free of charge. The late Tanzanian president John Magufuli also encouraged the use of herbal therapies and medicines to boost immune systems. In addition to his invocation of science, Ghana's President also spoke regularly about the value of a nutritious diet in the fight against the pandemic in his monthly broadcasts in 2020. There were many such initiatives by individuals and enterprises across Africa.

The negative international coverage of these unproven cures and elixirs from Africa notwithstanding, the studies have demonstrated that there were serious initiatives, inventions, and innovations in ways of doing things in response to COVID-19. While by far the greatest number of these responses were in the field of health, sectors such as education, social security, governance, and the economy also reported innovations.

The largest number of innovations were ICT related, and this is understandable given that the greatest challenge facing the world was how to resume normalcy without risking infections and deaths. Several apps were developed for contract racing (Ghana, Kenya, Nigeria), mobile apps for check-up and monitoring of sick persons (Ghana), for diagnoses (Burkina Faso), the management of patient information (Burkina Faso), for pharmacy management (Burkina Faso) tele-medicine (Nigeria) and health assistant,

[55] The monthly numbers of protests during the period February-December were 705, 233, 516, 934, 789, 397, 751, 871, 1025 and 1149. (The organisation was unable to provide a figure for March.)
[56] https://www.reuters.com/article/us-health-coronavirus-cameroon-treatment/cameroon-archbishop-says-treating-covid-19-with-plant-based-remedy-idUSKBN23N28K

smart home system (Mali). Digital platforms for connecting doctors and patients, including patients in remote areas (Burkina Faso, Nigeria), for managing patients' medical information (Burkina Faso), a COVID triage tool for patient self-assessment (Nigeria), a platform for civic, health and education information and a 'Stop Corona' interactive voice service was also established (Niger). Still in the ICT field, innovations included the use of robot nurses in Rwanda and robot police in Tunisia, while in Nigeria, an on-demand emergency medical oxygen delivery project was facilitated by ICT (UNDP, 2020; Darkwah, 2021; Ferguson, Satchi, Kizito & Kuria, 2021; Obiakor, Iheonu & Ihezi, 2021; Osei-Boateng & Vlaminck, 2021; Pambè, Dorte & Darkwah, 2021; Idrissa, 2021; Traoré & Diarra).

The production of medical, hygiene and sanitary equipment and devices was another strong area of innovation. In several countries, private sector operators, non-profits, and educational and research institutions produced hand-washing systems (sinks, basins, and buckets) in Burkina, Ethiopia, Ghana, Kenya, Mali, Nigeria, and Rwanda. In response to fears about the state of medical services, several companies designed and produced prototypes of cost-effective ventilators (Ethiopia, Ghana, Kenya, Nigeria, and Uganda) diagnostic testing kits (Ghana and Uganda), masks of all kinds- surgical, biodegradable transparent masks, self-sanitising masks, face shields (Ghana, Kenya, Uganda, Nigeria). Other inventions were a thermal imaging detection system (Uganda), AI powered smart home system (Ghana), and nasal swabs (Kenya). To remedy the lack of infectious disease facilities, hospitals were constructed in record time with prefabricated and other technologies (Burkina Faso and Ghana) (Teshager & Chofana, 2021; Darkwah,2021; Munu, & Vlaminck, 2021; Ferguson, Satchi, Kizito & Kuria, 2021; Obiakor, Iheonu & Ihezi, 2021; Osei-Boateng & Vlaminck, 2021; Pambè, Dorte & Darkwah, 2021; Traoré & Diarra, Ferguson, Lambert-Peck, Kapsandui, & Kuria, 2021).

All countries instituted e-learning systems including online learning sites and platforms using telephone, television, or computers. In addition, educational innovations included software for distance learning (Burkina Faso), mobile classroom and indigenous mobile learning platform (Nigeria). An example of a project that was responding to the access issues in the educational system was the CivicX Northern Code Project which was a digitization of STEM education content in the predominant local languages which was broadcast on national and local TV stations across the five Northern State in Nigeria. Online markets sprung up in Nigeria, Ghana, and Uganda while in Nigeria, public agencies established an app for social service delivery. This facilitated the delivery of funds to thousands of beneficiaries of COVID-19 supported programmes. In the field of research, Ghana and Burkina Faso reported research to sequence the COVID-19 genome (Ghana) and to generate epidemiological and socio-anthropological knowledge to strengthen COVID responses (Burkina Faso). (Darkwah,2021; Ferguson, Satchi, Kizito & Kuria, 2021; Obiakor, Iheonu & Ihezi, 2021; Osei-Boateng & Vlaminck, 2021; Pambè, Dorte & Darkwah, 2021)

The commonalities in the innovations and inventions across our study countries are not remarkable given the similarities in both containment and mitigation measures across the globe. It is noteworthy though, that these responses were at a time of fear of a massive impending crisis when the enforced closure of borders and the truncation of mobility and trade led to a race to strengthen self-reliance and the capacity to solve problems. In Africa, there was interest in technologies and innovations that were appropriate and frugal, for situations with energy, technology, and financial deficits. While many of these interventions were borrowed from other contexts, they were innovative in the sense that they represented a new effort to envision a world in which African countries could rely on their own scientists and industries to produce vital needs. It is

therefore not accidental that in all the twelve countries, there were several innovations that were ICT use. This is even more remarkable because of the wide gaps in ICT coverage between Africa and the world. With respect to manufacturing, it soon became clear that certain kinds of equipment and supplies were easier to produce and disseminate than others. Locally produced masks and other PPE, hand-sanitizer, liquid soap, and washbasins, items that were more likely to have a ready market became more common than ventilators and certain inventions that would require additional investments by the state in research and development. Therefore, while the nascent digital transformation in Africa is not yet established, it is important to register its capacity to either widen or bridge the technology divide, depending on how its implementation is handled as well as trends in the wider economy.

In the case of manufacturing, the adaptability demonstrated by alcohol producers branching into producing hand sanitisers and rubbing alcohol, sanitary paper producers branching into face masks and clothing lines branching into PPE gowns signals the existing of potential that can be deepened to ameliorate the massive loss of jobs and strengthen the industry and manufacturing in Africa.

Another important innovation is the range of solidarity and self-help arrangements at the level of communities that provided food and other support to persons in crisis, as the limits of the state social security system was exposed by the crisis. This is an area which showcases the continued relevance of non-state actors as well as ubuntu and self-reliance principles in action on the ground. Interestingly, some of the poorest countries such as Niger (Idrissa, 2021) and Mali (Pambè, Thorsen & Darkwah, 2021) reported some of the most interesting examples of solidarity, although this was an Africa wide response to the pandemic. Non-state solidarity should be formally taken up in the redesign of social policy, as a complement to the state financed social policy. This would strengthen the sustainability of the social policy framework. The potentials of all the innovations and inventions lie in continuous research, improvement, and dissemination. Besides, many innovations such as e-solutions require a certain level of infrastructure, telecommunication, electricity, and citizens with the capacity and appetite to adopt these.

7. Recommendations, Gaps in knowledge and new directions for policy, research, and practice.

There are several key messages of this synthesis report. The first is that with respect to mitigation and support measures, African countries emulated each other in drawing on local inspiration and practices from around the world. The uniformity of containment and mitigation measures raise questions about whether country specificities and the views of citizens were sufficiently considered. The appearance of uniformity notwithstanding, the sum of measures for each country has differed in terms of the combination of measures, target populations, budgets, intensity of implementation, levels of compliance and who are considered most badly affected. Country contexts and underlying socio-economic and political conditions also played a critical role in shaping responses to COVID-19 by government and civil society. Many of the mitigation efforts in Africa were short-lived and poorly implemented. In several cases, governments have returned to austerity and business as usual to realign with the dominant neo-liberal policy frameworks of the pre-COVID-19 era. Thus, the window that opened with the raft of experimental social policy measures is fast closing, in situations where some of the worst economic and social effects of the pandemic have not been addressed.

The findings from the various country studies also support the conclusion that state and societal responses to COVID-19 in Africa have been characterised by conflicting imperatives and differentials in power and influence with implications for the choice of measures and how long they were in place for, policy outcomes- who won and who lost, who gained and who lost influence. In the first instance, the influence of the African CDC and WHO on Africa's health responses grew and in the early stages, appeared to compete with economic imperatives. However, once the socio-economic impacts of containment measures began to unfold, mitigation measures that governments put in place as well as the loosening of some containment measures revealed the influence electoral politics, business associations and religious leaders on government decision-making. Currently, there is little appetite in many African countries for drastic lockdowns, and a much-reduced compliance with social distancing and masking in public places is tolerated, despite the more serious impacts of the current third wave in terms of infections and fatalities.

The third message is that severe containment measures have been critiqued as over the top, and in some cases involving human rights abuses and creating existential crises for poor and not so poor households. Furthermore, both containment and mitigation measures are deepening inequalities or creating new forms of poverty because of faulty targeting, the exclusion of certain categories of persons and the short-term focus of measures. Finally, the studies find that the lack of robust and up to date population data, participation deficits and patronage have been a challenge to government responses to COVID-19. The studies also highlighted the need for inclusive and democratic crisis management systems. The heavily technicist approach and centralisation of decision making by governments across the continent excluded civil society organisations (CSOs) and affected people, thus constraining the effective implementation of containment measures. (Rajan & Koch, 2020). raising questions of transparency, accountability, and corruption. This has had serious political implications in terms of rising tensions between government and the citizenry, the unravelling of the liberal democratic consensus, the closing of civic space and the loss of trust between citizens and governments.

Based on these findings, country studies have made recommendations in five broad areas- strengthening data collection systems and policy institutions; economic support, social policy, and social services; participatory democracy and partnerships.

On question of data, several studies recorded the urgency of establishing and strengthening the bio and social statistical database and institutions to enable governments keep updated registers of the general population and those in need as a strategy to stay steps ahead of pandemic effects and reaching those urgently in need in a consistent and effective manner. While several countries had registers for the poor, it became evident that keeping them constantly updated was an uphill task. Where data sources existed, there was a recommendation that mechanisms needed to be found to rid their application of patronage. Beyond the use of data to identify beneficiaries of social protection programmes, all aspects of policy making and implementation from taxation to universal systems of access to services and income would benefit from up-to-date systems of population registration and identification. Linked with this question of data is a debate about the value of registration for the formalization of informal enterprises and employment as a crucial step to address the precarity of work and the loss of employment and income because of COVID-19.

Recommendations about economic support include building capacities in fiscal and monetary policies and policy management, tax reliefs for informal business and own account workers, building permanent structures for the informal sector. The focus of recommendations on the informal economy speaks both to its importance and to the realisation that by far the most seriously affected by COVID-19 disruptions are people in the informal economy.

This focus on informal workers also runs through the social policy recommendations. The first concern strengthening financial aid programmes for different socio-economic groups and strengthening the coordination of financial aid. Other recommendations in social policy concern health monitoring for vulnerable and elderly people, making the wearing of face masks mandatory everywhere, enhancing medical attention for pregnant and breastfeeding women, instituting and strengthening targeted social protection programmes and tailor made policies instead of one size fits all approaches, the creation of emergency responses to access help in cases of violence, complementing social protection measures with support for rural citizens and mainstreaming social inclusion. Additional recommendations include the strengthening of efforts to subsidize agricultural production and establishing emergency feeding programmes to reduce food price inflation and guarantee food security. There are also recommendations for establishing legal and social rules for the protection of employment and income generating activities and to oblige companies to assume their social responsibilities.

Regarding participatory democracy, recommendations pertained to strengthening and improving decentralisation in all its dimensions and reducing the power of community level patronage systems in the implementation of decentralisation programmes. Another set of recommendations in this area pertain to increased transparency in decision-making, early engagement with communities and the private sector, better coordination between different stakeholders, involving non-state actors and local stakeholders in the design, planning and governance of COVID-19 responses and in revisiting policies and improving the reliance on social dialogue.

Under partnerships and alliances, the main recommendations are the establishment of strong partnerships at different levels- local, national, and global and presenting a clear plan to donors to secure more support.

Beyond recommendations, a critical finding of the country studies is that there is still much to learn about the future arc of the COVID-19 pandemic and its implications for Africa in the medium and long-term. This lacuna has policy implications. The stimulus packages that were instituted to address COVID-19 impacts were based on the expectation of a short and easily reversible pandemic shock, which meant that structural systemic issues of inequalities and unsustainability were not on the agenda (Ossome, 2021).

The question of what to attribute to COVID and how to measure impacts aside, there is the issue of which COVID related changes in the political economy, livelihoods and the society are temporary or permanent. Most African countries still do not have accurate and up to date information on the numbers of people who have lost jobs, fallen into poverty and who therefore need short-term assistance. Even more critical, what fundamental changes and what kind of restructuring of economies and societies are required to address the precarity of work, the endemic poverty of many workers, the gender, class, and racial inequalities within countries, between regions and across the globe? A related question concerns how to shift the focus from

temporary social protection and cash transfers to issues of universal basic income and universal access to services as tools for tacking crises, and for promoting social equity and human dignity.

What would several years of managing the pandemic mean for African civil society which has shown resilience in parts could also be at breaking point? The upsurge in solidarity, communal mutual support strategies for food security, solidarity, and domestic resource mobilisation; the increasingly angry demands for reforms of authoritarian and corrupt states; and the range of innovations emanating from civil society show that society is in ferment. We need fine grained studies to enable a deeper understanding of COVID-19's implications for civil society in Africa.

The contractions in Africa's economies because of COVID-19 impacts generated debates centred on structural transformation of economies, their agri-food systems and other sectors, population and social structure and social relations. In this connection, questions being debated include alternatives to the current neoliberal development model which was already in crisis before the pandemic. The starting point of these debates is that COVID-19 provides the opportunity for African countries to develop their economies, industries, promote indigenous knowledge, homegrown innovations and to invest in research and development (Kanu, 2020). Additionally, there is discussion about how African countries can leverage COVID-19 related innovations. Given the nationalism and protectionism that has characterized responses to the pandemic, the African Continental Free Trade Area (ACFTA) is seen as one of the vehicles that can propel intra-African trade and create solidarity and to rally the continent to move away from its current primary commodity dependence. This optimism about ACFTA should be understood in terms of assumptions that have been made about the possibilities it provides for regional integration in Africa, which do not consider its neoliberal underpinnings, and the threats its open regionalism agenda poses for Africa's economic integration.

Going forward, there is the need for research which interrogates some of the quick research to assess the impacts of COVID-19 which will become influential in policy circles and fresh research that accompanies debates and discourses on how to address inequalities, structural transformation, democratic failures, innovations, civil society and community responses, the struggles, and social movements. It is also an opportunity to re-examine strategies for African transformation that before the pandemic were considered utopian.

References

African Development Bank (2021). *African Economic Outlook 2021*. Abidjan: AfDB

African Development Bank (2021). *African Economic Outlook 2021*. Abidjan: AfDB

Amadasun, S. (2020). COVID-19 palaver: Ending Rights Violations of Vulnerable Groups in Africa. *World Development*, 134 (2020) 105054

Arndt, C; Davies, R, Gabrie, S, *et al.* (2020). Covid-19 Lockdowns, Income Distribution, and Food Security: An Analysis for South Africa. *Global Food Security*, 26 (2020) 100410

Barugahare, J. *et al.* (2020). Ethical and human rights considerations in public health in low and middle-income countries: an assessment using the case of Uganda's responses to COVID-19 pandemic. *BMC Medical Ethics*, 21(1), p. 91.

Berkhout, E; Galasso, N, Lawson, M et al (2021). The Inequality Virus: Bringing together a world torn apart by coronavirus through a fair, just, and sustainable economy. Oxfam briefing Paper

Cabore, J. W., Karamagi, H. C., Kipruto, H., Asamani, J. A., Droti, B., Seydi, A. B. W., Titi-Ofei, R., Impouma, B., Yao, M., & Yoti, Z. (2020). The potential effects of widespread community transmission of SARS-CoV-2 infection in the World Health Organization African Region: a predictive model. BMJ Glob Health, 5(5), e002647. 10.1136/bmjgh- 2020- 002647

Chigudu, S. (2019) The Politics of Cholera, Crisis and Citizenship in Urban Zimbabwe: 'People Were Dying Like Flies'. *African Affairs*, 118(472), 413–434

Dzigbede, K.D& Pathak, R. (2020). COVID-19 Economic Shocks and Fiscal Policy Options for Ghana. *Journal of Public Budgeting, Accounting & Financial Management*, 32(5), 903-917

Echoru, I. *et al.* (2020). Religion influences community adherence to COVID-19 guidelines in Uganda. *Research Square*. doi: 10.21203/rs.3.rs-59701/v1.

Ekumah, B; Armah, F.A, Yawson, D.O *et al.* (2020). Disparate on-site, Access to Water, Sanitation, and Food Storage Heighten the Risk of COVID-19 Spread in Sub-Saharan Africa. *Environmental Research*, 189 (2020) 109936, https://doi.org/10.1016/j.envres.2020.109936

Finn, B.D & Kobayashi, L.C (2020). Structural Inequality in the Time of COVID-19: Urbanization, Segregation, and Pandemic Control in sub-Saharan Africa. *Dialogues in Human Geography,* 10(2), 217–220

Kamazima, S.R(2020). "Is this War?": A Closed Border, Tense Border Standoff, Ruined Expectations and Imminent COVID-19 Disaster in the Tanzania-Uganda Borderlands. *International Journal of Advanced Scientific Research and Management*, 5(10),35-43

Kamazima, S.R, Kazaura, M & C. V. Kakoko, D.C.V. (2020) From Hospitality to Hostility: Border Crossing Experiences among Unsung Heroes on the Wheel in COVID-19-Hit East Africa. International Journal of Advanced Scientific Research and Management, 5(9), 143-157

Kanu, I. A. (2020). Covid-19 and the Economy: An African Perspective. *Journal of African Studies and Sustainable Development*, 3(2), 29-39

Leininger, J; Strupat, C; Yonas, A, *et al*. (2021). The Covid-19 Pandemic and Structural Transformation in Africa. Discussion Paper 11/2021. Deutsches Institut für Entwicklungspoliti: Bonn

Maffioli, E. M. (2020). How Is the World Responding to the Novel Coronavirus Disease (COVID- 19) Compared with the 2014 West African Ebola Epidemic? The Importance of China as a Player in the Global Economy. *Am. J. Trop. Med. Hyg.*, 102(5), 924–925 doi:10.4269/ajtmh.20-0135

Meyer, B. (2020). *Pandemic Populism: An Analysis of Populist Leaders' Responses to COVID- 19.* London: Tony Blair Institute for Global Change.

Nkengasong, J.N; Ndembi, N.; Tshangela, A & Raji, T. (2020). COVID-19 Vaccines: How to Ensure Africa has Access. *Nature*, 586(2020), 197-199

Obeng-Odoom, Franklin. (2020). COVID-19, inequality, and social stratification in Africa. *African Review of Economics and Finance*, 12(1), 3-37

OCHA (2020). Aperçu des besoins humanitaires Burkina Faso. OCHA

Oduro, Abena, D., & Tsikata, D. (2020). *Gender Analysis of Ghana's COVID-19 Response Measures*. Prepared for Network for Women's Rights (NETRIGHT) Ghana.

Ossome, Lyn (2020): The care economy and the state in Africa's Covid-19 responses, *Canadian Journal of Development Studies* / Revue Canadienne D'études du Développement, DOI: 10.1080/02255189.2020.1831448

Paci, P. (2021). How livelihoods deteriorated in Sub-Saharan Africa due to COVID-19. https://blogs.worldbank.org/africacan/how-livelihoods-deteriorated-sub-saharan-africa-due-covid-19(Accessed, September 1st, 2021)

Qureishi, Z. (2020). Tackling the inequality pandemic: Is there a cure? Washington: Brookings Institution

Rajan D& Koch, K. (2020). The Health Democracy Deficit and COVID-19. *Euro Health*, 26(3), 26-28

Tangwa, G. B & Munung, N. S (2020). COVID-19: Africa's Relation with Epidemics and some Imperative Ethics Considerations of the Moment. *Research Ethics,* 16(3-4), 1–11

The International Bank for Reconstruction and Development and the World Bank (2021). Resilience: COVID-19 Crisis through a Migration Lens. Migration and Development Brief 34. Washington DC: World Bank

UNDP. (2020). Africa Innovates: 50 Homegrown African Innovations Tackling COVID-19. New York: UNDP

UNDP (2021). Analysing long-term socio-economic impacts of COVID-19 across diverse African contexts

United Nations Commission for Africa. (2020). Economic Effects of the COVID-19 on Africa. UNECA: Addis Ababa.

Williams, Caitlin R; Kestenbaum, Jocelyn Getgen& Meie Benjamin Mason. (2020). Populist nationalism threatens health and human rights in the COVID-19 response. *AJPH*, 110(12), 1766-1768

Country Reports

Darkwah, K. Akosua. (2021). Ghana country study on covid-19 measures and impacts.

Ferguson, Laura, Lambert-Peck, Miles, Kapsandui, Tonny & Kuria Shiphrah. (2021). Uganda Country Case Study: Equity in COVID-19 mitigation and policy responses.

Ferguson, Laura, Satchi, Krishni, Kizito Irene & Kuria Shiphrah. (2021). Kenya Country Case Study: Equity in COVID-19 mitigation and policy responses.

Hassen, Majdi, Marouani Mohamed Ali & Wojcieszynski Emilie. (2021). Mitigation strategies in response to COVID-19 and inequalities in Tunisia.

Idrissa, Abdourahmane. (2021). Niger in the year of the covid-19 pandemic: the fear, the grief, and the coping.

Munu, Martin, Luther. & Vlaminck, Zjos. (2021). Beyond the curve: equity in Rwanda's COVID-19 response.

Nuvunga, Adriano; Collet, Angela, Machava, Agostinho & Dimas Sinoia. (2021). Equity in COVID-19 pandemic response measures/policies in Africa: Mozambique Case Study.

Obiakor, Thelma, Iheonu Chimere & Ihezi Ezra. (2021). The Equity Implications of COVID-19 Responses: A Case Study of the Informal Economy and the Education Sector in Nigeria.

Osei-Boateng , Clara & Vlaminck, Zjos(2021). COVID-19 in Ghana: a looking glass into structural

inequalities and political distrust.
Pambè, Madeleine Wayack, Thorsen Dorte, Darkwah Akosua K. (2021). Burkina Faso country study on COVID-19 measures and impacts.
Teshager Kassa & Chofana Tesfaye. (2021). Equity in COVID-19 mitigation and policy responses in Africa: Ethiopian case study.
Traoré, Ousmane, Z & Diarra Djénéba. (2021). Preventive strategies and social policy measures in response to COVID-19 and the socio-economic vulnerability of households in Mali.
Wantchekon, Leonard & Koumassa, Leonie. (2021). COVID pandemic and Inequality: Are Benin's mitigation actions and strategies inclusive?

Appendix 1: Additional Tables

Table 15: Labour Force participation Rate in 2019 (% of population 15 years)

Country	Female (%)	Male (%)
Benin	69	73
Burkina Faso	58	75
Ethiopia	73	85
Ghana	64	72
Kenya	72	77
Mali	58	81
Mozambique	77	79
Niger	61	84
Nigeria	49	63
Rwanda	84	83
Tunisia	25	69
Uganda	67	73

Source: World Bank

Table 16: Wage and salaried workers (2019)

Country	Female (%)	Male (%)
Benin	6.2	17.5
Burkina Faso	11.3	16.7
Ethiopia	13.4	18.0
Ghana	18.1	35.3
Kenya	42.8	58.4
Mali	12.9	24.7
Mozambique	6.8	25.4
Niger	1.8	7.3
Nigeria	14.6	24.7
Rwanda	23.7	44.4
Tunisia	85.7	71.4
Uganda	16.8	28.3

Source: World Bank

Table 17: Vulnerable employment

Country	Female (%)[57]	Male (%)
Benin	93	81
Burkina Faso	88	82
Ethiopia	86	81
Ghana	77	58
Kenya	54	41
Mali	87	74
Mozambique	56	71
Niger	98	92
Nigeria	85	75
Rwanda	76	56
Tunisia	11	21
Uganda	80	67

Source: World Bank- Derived using data from International Labour Organization, ILOSTAT database.

[57] https://data.worldbank.org/indicator/SL.EMP.VULN.FE.ZS?view=chart

Table 18: Common Support Measures			
HOUSEHOLDS			**BUSINESSES**
Access to Services	**Social Safety Nets**	**Income Protection**	**Business support**
Access to services • Water and electricity subsidies (**All countries)** • Provision of free water to all informal settlements (**Kenya**) • Water supply to public standpipes in cities (Burkina **Faso**) • Medical care, counselling and support for disabled, vulnerable returnees and people on various addictions (**Ethiopia**) • Remote teaching via radio, TV and online	**Cash transfers**[58] • Cash transfers for people affected by Covid-19 (**All**) • Waiver of public works requirement for beneficiaries of safety net cash grants (**Ethiopia**) • Advance payment to urban and rural safety net beneficiaries (**Ghana**) • Establishment of a special fund for Mali's 703 communes administered in a collegial and transparent way with the public authorities, village and neighbourhood chiefs, civil society and the moral authorities designated by the beneficiaries themselves (**Mali**) • Expansion of existing conditional cash transfer programme (Nigeria**, Uganda)** • Welfare payment to retired persons receiving low pension amount (**Tunisia**) • Expansion of Social Assistance Grants for Empowerment (SAGE) program for senior citizens (Ethiopia**)** • Continuation of special Grant for Persons with Disabilities (**Uganda**) **Prisoner pardon** • Early release prisoners (Niger**, Ghana**)	**Income support** • Payment of a special premium to health personnel and components of the security and defence forces (**Mal**i) • Provisional exceptional allowance for affected self-employed people (**Tunisia**) • Ease of loan repayment conditions to borrowers (**Kenya**) • Deferral of repayments of bank loans for salary employees (• Loans for private school teachers (**Rwanda**) **Taxation** • Consumption tax ○ VAT exemption for goods used to fight COVID-19(**All**) ○ Reduction in communication tax (**Ghana**) • Reductions in Income tax () ○ Waiving of Pay as You Earn (PAYE) Taxes (All)Ghana, ○ Tax holiday for health workers (Ghana)	**Financial support** • Stimulus Package to Micro, Small-scale and Medium Enterprises (MSMEs) (Ghana, • Stimulus packages for Private Schools (Ghana) • Care Guarantee Scheme (GCGS) • Guarantee fund for the private sector **(Ghana**) • Special Line of Credit for Small and Medium Enterprises (SMEs) (**Mozambique)** • Direct support for MSMEs in the health sector (Mozambique**, Nigeria**) • Social Economic Recovery plan to support affected SMEs (Rwanda) • Bonus paid to companies with specific number of employees (**Tunisia**) • Acquisition of agricultural input and livestock feed for agricultural enterprises (**Rwanda, Uganda)**

[58] Beneficiaries include: poor women, chronically ill persons, children, living with disability, pregnant women without source of income, women with six or more dependents, families hosting internally displaced persons, children, elderly people, chronically ill people and disabled, internally displaced/refugees; disabled people; children in difficult situations; older people in absolute poverty; disabled people in absolute poverty; people with chronic and degenerative diseases; people benefiting from Basic Social Security policies; women heads of households, and street residents, vulnerable families in urban, peri-urban and border areas, families in distress, families with limited incomes, families caring for children without support, families caring for the elderly, families caring for persons with special needs, foreign families and students and retired persons receiving low pension amounts.

(All **countries**) • Provision of hygiene and personal protection material to vulnerable people, technicians, and employees (All) **Health** • Subsidy on nose masks (**Benin**) • Recruitment of more health workers (Ghana) • Health infrastructure expansion (**Ghana**) • Investment in research on infectious diseases and the production of drugs (**All**)	**Food security** • Secured stocks of consumer goods (sugar, milk, rice, oil, soap, etc)- **Burkina Faso** • Food distribution to vulnerable populations-**Burkina Faso, Ghana, Ethiopia, Uganda, Rwanda, Nigeria, Mozambique** • Free distribution of cereals (**Mali**) • Food distribution to final year students, teachers, and staff (**Ghana**) • Reduced prices of food items for vulnerable people (Niger) • Adoption of a price ceiling for essential food items such as grains, beans, bananas, sugar, rice, cooking oil, etc. – (**Niger)** • Food sourcing from the National Strategic Grain Reserve to support vulnerable households (Rwanda) • The reactivation of SONAGESS' (Burkina Faso National Food Security Stock Management Company) pilot shops (subsidised cereal sales) (**Burkina Faso)** • The securing of stocks of essential products (Burkina **Faso**)		• Economic revival fund for companies in distress (**Tunisia**) • Support for artisans and carriers (Benin) • Solidarity fund for informal sector businesses particularly those headed by women, to revive their vegetable and fruit trade (**Burkina Faso**) **Regulatory Policy Relaxation** • Favourable Monetary Policies • Lowering Central Bank Rate (**Kenya**) • Lowering of the Cash Reserve Ratio (**Kenya**) **Taxation** ○ Tax rebate for companies who retain their workers (**Tunisia**) ○ Tax Exemption/postponement microenterprises in the informal sector (**All**) ○ Tax exemption for formal businesses (**Benin**)

Table 19: Uncommon measures

Type of Measure	Measure
Access to services (7- Benin, Ghana, Nigeria, Rwanda, Uganda, Burkina Faso, and Mozambique)	• Online service for taxes payment **(Benin**) • Online service for judicial record acquisition (**Benin**) • Exemption from service fees related to transactions on mobile banking and ATM platforms (**Mozambique**) • Waiver of charges on mobile wallet (**Ghana**, **Mozambique**) • Lifting of transaction costs of mobile money (**Rwanda**) • 100% increase in the limit per transaction in the mobile wallet and in the daily transaction limit in the mobile wallet (Mozambique) • Fuel subsidy (**Nigeria**) • Subsidy for solar home system kits (**Nigeria, Burkina Faso**) • Agricultural inputs, seeds, and fertilizers access though e-vouchers (**Uganda**) • Sanitation and health counselling for commercial sex workers (**Ethiopia**) • Free distribution of cattle feed (**Mali**)
Housing (2- Ethiopia and Nigeria)	• Transitory shelters for urban destitute street children **(Ethiopia**) • Subsidised housing (**Nigeria**)
Food security (2-Ethiopia and Nigeria)	• Continuation of School Feeding Programme **(Nigeria**) • Food provision to commercial sex workers **(Ethiopia)**
Integration and family reunification (1- Ethiopia)	• Reunification of D&V group with family (**Ethiopia)** • Integration of vulnerable returned migrants with their families (**Ethiopia**)
Labour rights (1-Ethiopia)	• Employers instructed not to lay-off workers in public and private companies during state of emergency (**Ethiopia**) • Government monitoring of petitions from 366 labour organizations, opposition to layoffs, denial of wages and pay cuts and reinstatement of laid off workers reinstated (**Ethiopia**)
Business support (1-Burkina Faso)	• Free parking for taxis (**Burkina Faso**) • Suspension of rent of marketplaces (**Burkina Faso**)
Domestic Resource Mobilisation (4-Ghana, Ethiopia, Kenya, Burkina Faso)	• Renunciation of salaries of members of the government to contribute to the financing of Covid-19 prevention and mitigation measures (**Burkina Faso**) • Voluntary reduction in the salaries of the senior ranks of the National Executive (**Kenya**) • BOLSA in collaboration with the Ethiopian Federation of National Associations of Persons with Disabilities mobilized funds from development partners to provide food and sanitation assistance its members (**Ethiopia**) • “Sharing food with helpless neighbours” and "Our Health is in Our Hands" campaign in Ethiopia (**Ethiopia**) • Construction of 100-bed health facility in Ghana by private sector (**Ghana**)

Table 20: COVID-19 Related Inventions

Type of interventions and countries	Description
Health sector inventions- Burkina Faso, Ethiopia, Ghana, Kenya, Mali, Niger, Nigeria, Rwanda, Tunisia (**9**)	**ICT and medical services** • COVID-19 contact tracing app (**Ghana**) • MSAFARI A contact-tracing app (**Kenya**) • Contract tracking tool - GloEpid uses telco data from smartphones, GPS, and Bluetooth connection to trace the movements of those who have been potentially exposed to the virus (**Nigeria)** • Mobile Apps for check-up and monitoring (**Ghana, Ethiopia)** • DiagnoseMe" apps for smartphones (**Burkina Faso**) • *Mondjossi*, a platform for connecting users with the medical profession[59] (**Burkina Faso**) • ePresc (https://epresc.care/) a web/mobile application dedicated to the digital management of patients' medical information throughout their lives and throughout their care[60] (**Burkina Faso**) • DMS, a pharmacy management software that facilitates data traceability.[61] (**Burkina Faso**) • Wellvis Health, a telemedicine solution that digitally connects doctors to Nigerians geographically excluded from hospitals **(Nigeria)** • Robot-nurses **(Rwanda**) • Drones for medical delivery and care (**Ghana, Rwanda**) • Gerocare, which offers a subscription-based service that provides care-at-home for the elderly using real-time mobile technology (**Nigeria**) • e-health start-up Redbird launched the COVID-19 Daily Check-in App and Symptom Tracker (**Ghana**) • Deployment of robot police (**Tunisia)** • AirBank is an on-demand emergency medical oxygen delivery product that is the quickest, most convenient, and cost-effective way to order medical oxygen in cylinders (**Nigeria**) • Rona a COVID-19 specific data analytics chatbot (Kenya) • COVID-19 Triage Tool which is a free online tool that helps users to self-assess their Coronavirus risks categories based on symptoms and their exposure history (Nigeria) • Muryar Matassa digital platform for civic, health and education information sharing (**Niger**) • Stop Corona! Call 701 interactive voice service (**Niger**) • ASSA (Assistant Sanitaire Automatique) health assistant app (Mali) • Smart Home System, which can control lights, switches, sockets, elevators, and appliances with an app on the phone without touching surfaces (**Mali**).

[59]https://lefaso.net/spip.php?article95805
[60]https://lefaso.net/spip.php?article95811
[61] https://lefaso.net/spip.php?article96384

Medical, hygiene and sanitary equipment and devices/items- Burkina Faso, Ethiopia, Rwanda, Mali, Ghana, Kenya, Uganda, Nigeria (8)	• Pedal-powered hand-washing system (**Burkina Faso**) • Portable washbasins **(Ethiopia, Rwanda**) • Smart Hand washing device and stations- which are also environmentally friendly because we use solar power. The design is a 3-in-1 basin, which in auto sequence, dispenses soap, water and blows out hot air to dry the hands (Mali) • Cost effective ventilators (**Ghana, Kenya, Ethiopia, Uganda, Nigeria**) • Development of an automated modern testing kit **(Uganda**) • Rapid Diagnostic Test (RDT) kit (**Ghana, Uganda**) • Solar powered hand-washing basin (**Ghana**) • semi-automatic wooden hand washing machine (**Kenya**) • Surgical mask (**Kenya**) • Hands-free sanitizer dispensers (**Uganda**) • Biodegradable transparent face masks (**Uganda**) • Thermal imaging detection system (Uganda) • Self-sanitising mask (**Uganda**) • Respire-19 – a Portable Respirator- a portable E-vent automatic ventilator (**Nigeria**) • The GIVO face shield, locally made 100% reusable, recyclable, and eco-friendly (**Nigeria**) • Touchless Washing Buckets (**Nigeria**) • 3-D Printed Reusable (**Ghana**) • Recyclable Facemasks (**Ghana**) • AI-powered Smart Home System (**Ghana**) • Low-cost, mass-produced coronavirus nasal swabs using 3-D printing (**Kenya**)
Medical facilities Burkina Faso, Ghana **(2)**	• Proposal for the construction of a prefabricated hospital (**Burkina Faso**) • Construction of 100 bed medical facility in Ghana led by private sector (**Ghana**)
Education (All countries - examples)	• Software for distance learning (easyschool) (Burkina **Faso**) • Mobile Classroom an indigenous mobile learning platform that allowed all individuals across all school levels to learn contact-free (**Nigeria**) • Use of technology for learning (All**)** • Virtual/online learning sites and platforms (**All)** • The CivicX Northern Code Project which involves digitizing STEM education content, in the predominant local languages and broadcasting the content via free-to-air national and local TV stations currently across five northern states – Kano, Adamawa, Borno, Nasarawa, and Kaduna (Nigeria)
Online markets (All countries- examples)	• E-retailer (**Nigeria**) • Asigame **(Ghana**) • Market Garden (**Uganda**)
Apps for social service delivery Nigeria (**1**)	• Plax is an end-to-end technology platform that enables the delivery of value to target beneficiaries. Its objective is to aggregate and cascade valuable offerings to user beneficiaries, while ensuring transparency and accountability. The current users of the platform include the government, agencies, banks, and NGOs. During this pandemic, PlaX has facilitated the delivery of funds to thousands of beneficiaries of COVID-19 supported programs, and palliatives to households (**Nigeria**)
Research	• COVID-19 Genome sequencing (Ghana)

Ghana, Burkina Faso (2)	• Research to generate epidemiological and socio-anthropological knowledge to assist the country in its response to the pandemic

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