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KNOWLEDGE PLATFORM ON INCLUSIVE DEVELOPMENT POLICIES

Synthesis of Country Case Studies of Ghana and Burkina Faso

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Published May 2021

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Introduction

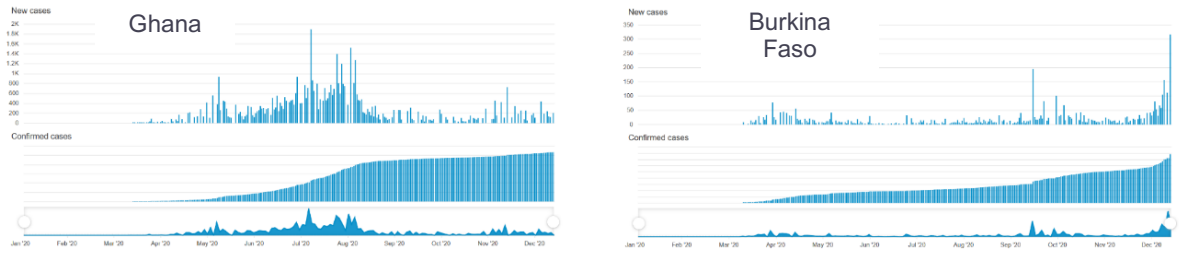
This synthesis paper explores how the unique contexts in Ghana and Burkina Faso produce a different set of actors and responses to the Covid-19 pandemic. Moreover, the paper explores whether these differences impact on the inclusivity of the responses. We use a feminist intersectionality lens that acknowledges the existence of multiple markers of difference as well as vulnerability to unpack the multi-dimensional effects of Covid-19 responses on citizens in Burkina Faso and Ghana. Gender is a key starting point for our analysis of marginalisation, but not the only frame of reference. We examine the impact of the crisis on other marginalised groups as well.

Although the economic and socio-political differences between the two countries are profound, there are some important similarities. Firstly, both countries have bias towards their larger cities while remote rural areas are marginalised in multiple ways. Secondly, they have a long history of high levels of mobility towards larger cities and abroad. As a result, they have large numbers of rural-urban migrants within the country and important diasporas in OECD countries which engage with the homeland. We therefore seek to add a spatial layer to the analysis to discern differences in the responses to Covid-19. Thirdly, 2020 was election year in both countries with general elections held on the 22 November in Burkina Faso and the 7 December in Ghana, requiring scrutiny of how political considerations might have influenced response strategies.

Among the critical differences between the two countries is the disparity in national economies, with Ghana being ranked as a lower middle-income country and Burkina Faso as a low-income country, which generates different donor and investment landscapes. Moreover, in addition to the well-established mobilities, insecurity arising from radical Islamist insurgency in parts of Burkina Faso since 2016 has produced new mobility patterns and distinct vulnerabilities among displaced populations and in the communities hosting large numbers of internally displaced people (IDPs). Because of this crisis international organisations such as the World Food Programme, UNICEF and the World Bank have an important presence and on-going crisis responses in certain areas of the country.

However, these are not the only critical differences. The spread of Covid-19 has developed rather differently in the two countries (Figure 1). Burkina Faso was the first country in Africa to record Covid-19 cases on the 9 March 2020, with Ghana following suit on the 12 March. By the 15 October Burkina Faso had a total of 2,294 confirmed cases (109.7 cases per 100,000 persons) while Ghana had reached a total of 47,126 confirmed cases (1,516.6 cases per 100,000 persons) after experiencing a first peak of Covid-19 in July and August. Two months later, Burkina Faso had its first peak but still only totalled 4,030 confirmed cases. Ghana managed to contain the spread of the virus, and the total number of confirmed cases had only risen to 52,933.[1] This is a significant difference, and in addition to causing dissimilar pressures on the public health system, it has instigated different attitudes in the population to their government's responses.

Figure 1.Confirmed Covid-19 cases, January - 15 December 2020 (Source: https://www.who.int/)



In the following, we analyse comparatively the two countries' response to the public health challenge triggered by the global pandemic, as well as the mitigation programmes to ease economic, social and educational consequences of the public health responses. Then we look at the advocacy that has surrounded responses to the epidemic and responses to mitigate its economic fallout. Next, we examine how Covid-19 policies have affected vulnerable people, and briefly look at the communication strategies employed to reach the populations in each country. Before concluding, we look into innovations emerging from response implementation during the pandemic.

Chapter 1. Attention to inclusion in policy and programme responses to Covid-19

In both countries the initial policies and interventions subscribed to a biomedical disease model with rapid responses to contain the pathogen and prevent further spread. Public health measures were put in place quickly, while mitigation measures dealing with the social, educational, and economic fallout of the public health measures trailed after.

Testing, contact-tracing and treatment structures

Indicators describing the situation in healthcare provision epitomise uncertainties regarding the existing health system's ability to cope with additional pressures of an unpredictable pandemic. National averages reveal a significant gap between the two countries, with Burkina Faso having one doctor to 12,000 persons and one nurse to 2,419 persons in 20182 and Ghana having one doctor to 8,431 persons and one nurse to 627 persons in 2017.[3] In regard to the physical access to public health care, the catchment population of health centres in Burkina Faso averaged 9,645 persons in 2018. However, averages conceal locational differences implying that rural populations may need to travel further to reach a health centre, while the population in more densely settled areas may have to wait longer to be seen. In Burkina Faso, they also disguise that 1.08 million people in the regions most affected by violence lacked access to healthcare in 2020 because local community health centres had closed due to security threats (amounting to 7.2 percent of the country's health facilities) and the displacement of people have increased pressure on health centres in other community settings.[4]

From the beginning of the Covid-19 pandemic, both countries took measures to prepare their public health systems. In Burkina Faso, the government's emphasis on public health provision appeared low key and restricted to the requisitioning of a hospital centre in a suburb of Ouagadougou to isolate Covid-19 patients. A few days after the first case had been identified, there were only 400 Covid testing kits available in Burkina Faso according to Al Jazeera, and only three health facilities in the country were able to carry out tests – two in Ouagadougou and one in the second city, Bobo Dioulasso.[5] However, international donors, such as the World Health Organisation (WHO), the Economic Community of West African States (ECOWAS), the West African Monetary and Economic Union (UEMOA), the Republic of China, Plan International and Doctors without Borders financed laboratories for testing, provided technical assistance and training, and supplied personal protective equipment (PPE) to healthcare professionals through the National Health Emergency Response Operations Centre (CORUS), for which the Ministry of Health had received budget support since November 2018 from the Bill and Belinda Gates Foundation.[6] Contact-tracing in Burkina Faso was supported by WHO, UNICEF and Terre des Hommes. In May, a National Committee for 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.

In Ghana, the government focused on consolidating the ability of the health care system to cope by increasing the medical staff to population ratio through employing 65,000 health professionals and offering economic incentives to frontline workers to ensure consistency and quality of healthcare. Even without evidence of the distribution of healthcare professionals in Ghana or the duration of their employment, the extent of recruitment suggests a better outreach than was observed in Burkina Faso. In Ghana, the private sector was a major source of funding. The COVID-19 Private Sector Fund rolled out

a comprehensive fund-raising campaign, which made possible the delivery of a 100-bed infectious disease and isolation centre as well as a 21-bed intensive care unit and a biomedical laboratory in the Greater Accra region in July. By early September 2020, the fund had raised a total of GH¢43.16 million (€6.17 million). World Food Programme (WFP) donated 10,800 bags of nutritious enriched food to feed Covid-19 patients in isolation. International and private sector donors, including banks, mining companies and churches, provided testing kits and laboratory equipment to run a test and trace system, while the state employed trained community health nurses to do contact-tracing. Highly educated health professionals in the diaspora and at home engaged in information campaigns through WhatsApp groups and other channels to prevent further spread of the virus and continues to do so by targeting vaccine hesitancy.[7]

Although the differences between the two countries' existing medical structures, especially in the ratios of healthcare professionals to population, imply an immense disparity in access, the important difference at the beginning of the pandemic was the source of financing. While Burkina Faso relied primarily on international donors with modest contributions from the diaspora[8], Ghana was able to mobilise its business community, including the diaspora, of whom many worked in healthcare and tech professions. Technical solutions adhering to the biomedical disease model were thus at the centre of private sector initiatives and were shrouded in a "we can do this" attitude. As a contrast, technical solutions in Burkina Faso were surrounded by an international discourse on the country's inability to cope, as epitomised by the United Nations High Commission for Refugees' (UNHCR) warning in early April "that the pandemic would further stress Burkina Faso's poor healthcare system and economy" and that the country "had one of the fastest infection rates in sub-Saharan Africa with millions potentially at risk."[9]

Proactive containment measures

Comprehensive containment measures were issued swiftly in both countries. Within days of the first confirmed cases, both governments issued temporary border closures. Establishments likely to gather large numbers of people, such as education institutions, markets, shops, the hospitality sector, and places of worship, were also ordered to close temporarily. Ghana closed all schools three days after the first Covid-19 case and Burkina Faso less than ten days after its first case. Partial lockdowns were decreed. In Burkina Faso, cities with confirmed Covid-19 cases were quarantined for two weeks to hinder spread to other locations, a nation-wide night curfew was issued, markets and other businesses across the country were ordered to close from the 26 March until the 20 April, and public gatherings of more than 50 persons were prohibited, as were private gatherings of more than 40 persons. In practice, markets in smaller cities with no confirmed cases did not close but the attention paid to hygienic containment measures intensified.[10] In Ghana, the government decreed a three-week partial lockdown in the two largest cities from the 27 March. Urban and rural populations were thus affected differently by the containment measures affecting livelihood activities immediately.

Further containment measures followed WHO recommendations and international trends, with calls for increased attention to hygiene and physical distancing. In both countries, the emphasis was on the provision of handwashing facilities and/or alcoholic gel, and later the wearing of face masks in public spaces. In Burkina Faso, the latter measure became compulsory nation-wide from the end of April, while in Ghana the use of face covering was encouraged at first but made compulsory from mid-June. In both countries, non-state actors rallied together to provide handwashing stations and hand sanitizer gel to places that could be super spreaders, and face masks to vulnerable people.

The similarity between the range of containment measures issued in the two countries, their coverage and timing is remarkable. The measures were biased towards the largest cities where the population densities could accelerate the spread of the virus, but often framed as targeting everyone. Covid adaptations in rural areas have received little media attention. However, given the few cases of Covid-19 outside the larger urban conglomerates, adherence to the measures and enforcement in rural areas is likely to have been low.

Mitigation measures

Although the focus of containment measures was primarily on the big cities, the fallout was nationwide. Additionally, the segments of the population in both countries who rely on remittances from transnational migrants were likely to experience a drop in income due to Covid-19 and the fallout of containment in other countries.[11] Some families may even have had to support migrants travelling over land and getting stuck due to the closure of borders[12]. At the national level, the price of food and consumer goods increased in both countries, and a large segment of the population experienced a decrease in income due to the temporary closures impeding trade and services. In Ghana, for example 77.7 percent of the population faced lower incomes and just over half the population reduced their food consumption.[13] Measures to mitigate the fallout from containment strategies have addressed three areas primarily, subventions to enable people to stay at home, schooling, and assistance to businesses. Significant differences emerge in these three areas.

Both governments provided substantial subsidies for basic utilities such as water and electricity. In Ghana, the provision of electricity was subsidised from April to the end of September while water was provided free till the end of December. The lowering of financial burdens for the population seemed inclusive, however the approach took no notice of existing geographical, class and gender inequalities. Regarding water, Ghanaians do not enjoy universal access to pipe borne water, and as a result the subsidy bypassed more than half the population, including those in the poorer income quintiles and the rural population. During the duration of the lockdown water tankers delivered water to urban neighbourhoods outside the grid but some tanker drivers argued that while the water was free, the transportation costs had not been covered by the government and therefore they charged consumers. The electricity supply is wider, with around 82 percent of households nationwide having access. Nevertheless, only around 75 percent of the population benefitted from the electricity subsidies and those missing out were more likely to be poor female-headed households in the North than wealthier male-headed households in the South.[14]

In Burkina Faso, the government introduced subsidies for the basic utilities for three months to alleviate the pressure of additional costs in poorer households. In principle, all households were exempt from paying for water. In practice, as most rural households collect water for free from communal boreholes, wells or rivers, the subsidy bypassed them. In urban areas, 93.5 percent have access to pipe borne water in their houses, compounds or at nearby communal taps.[15] However, the government disregarded that the water supply was unreliable, as is common at the height of the hot dry season from March to June, leaving many households with infrequent and/or insufficient water supply. No water distribution assistance was offered and the work burden of procuring water at all times of the day or night fell heavily on women and girls. The electricity supply is heavily biased towards urban areas, in 2014 only 9.3 percent of rural households were connected to the grid compared to 62.4 percent of the urban households.[16] Consequently, mostly urban households benefited from the means-based subsidy offered by the government. Low consumption households were exempt from paying bills for three months, while medium consumption households were offered a 50 percent rebate on their bills.

In both countries, subsidies were biased towards the urban population without considering structural inequalities relating to the spatial distribution of wealth at the national level or locally within urban areas. No explicit attention was given to inclusivity in the measures and no specific measures were implemented to support the most vulnerable households beyond the tiered subsidies in Burkina Faso. Thus, much of the rural population, as well as the urban poor were excluded from benefitting from mitigation measures.

The swift school closures left no time for planning for educational continuity for all school children. In Burkina Faso, the Ministry of National Education, Literacy and Promotion of National Languages (MENAPLN) presented a response plan one month after schools were closed. Only two of five action points focused on the provision of education during closure, the rest were focused on virus containment strategies and on the completion of the school year in person without further delay. The two action points to ensure continuity hinged ambitiously on the production of digital teaching resources for all levels of schooling up to and including secondary schooling, which were to be disseminated through radio, television, online press, android applications, downloadable files and removable media. In Ghana, the Ministry of Education (MoE) and Ghana Education Service (GES) coordinated the mitigation responses. Emphasis was on the creation of educational content to be played on television and radio in 30-minute repeated sessions. Children of the elite who attended high-end private schools were provided with online learning by their schools that ensured time with their teachers and opportunities to do homework. Such differentiated tuition inevitably exacerbated existing inequalities in the education system. However, the MoE/GES were not oblivious to this fact but stated they would seek to provide equipment and connectivity, ensure accessibility, encourage support by parents and caregivers and help structure learning for the most vulnerable children, including those with special needs.[17] While we have not found evidence in the media of the extent of these provisions, there are indications that they have not reached all school students living with disability. Hearing impaired students, for example, have had difficulties of accessing online learning if captions were turned off, and attempts by teachers to reduce data needs for all students by turning to PowerPoint slides, excluded visually impaired students.[18]

School closures extended longer than first envisaged due to subsequent containment strategies. In both countries, schools only opened for final-year students in June. In Burkina Faso, all students returned to school in September, while in Ghana, only the new classes of final year students had ten weeks of schooling in the second half of 2020, with a view to fully reopening schools in January 2021.

Several factors intersected to widen the educational gap further and wider in both countries. Firstly, differences between urban and rural areas in the access to electricity and ownership of TV and radio put rural children at a disadvantage. In Ghana, only about one-third of northern households owned a TV compared to two-thirds of southern households[19] and in Burkina Faso the near absence of electrification in rural areas bared most children from accessing televised lessons. Radio-based lessons did not fare better, as few children access a radio of their own. Secondly, poverty and gender further intersected, implying that children in poor households were even more unlikely to access televised teaching if the household head was female than if the head was male. Thirdly, parents with little or no school education were not able to support their children's home learning, thus exacerbating the intergenerational transmission of disadvantage.[20] Fourthly, the gender of the school child intersected with the other factors, as girls in both countries were more likely to be allocated domestic chores at the expense of their schoolwork.

Data from Ghana reveal that 35 percent of the students in primary school and 28 percent in secondary school had absolutely no form of education during school closure.[21] We do not have similar data for

Burkina Faso, but the insurgency in the north and east of the country had already affected the schooling of more than 300,000 children due to school closures and displacement.[22] Although the government could have addressed the continuity of schooling for children from these areas since 2018, distant learning strategies were only planned after the outbreak of Covid. The mitigation strategies adopted in both countries were inadequate and consequently, educational inequalities will be rising steeply, with gender, class and location intersecting to disadvantage girls from poor households in rural communities the most.

Finally, efforts to mitigate the fallout of market and business closures on small and medium sized enterprises (SMEs) reveal significant differences between the two countries. By mid-May, the Ghana National Chamber of Commerce and Industry (NCCI) pointed to the scale of loss by disclosing that about 108 businesses had lost roughly GH₵39.8 million (€5.65 million) due to the pandemic. This resulted in the government and the National Board for Small Scale Industries (NBSSI) coordinating two schemes to support businesses, drawing on expertise and financing from business and trade associations and commercial and rural banks. The Corona virus Alleviation Programme Business Support Scheme (CAP BuSS) aimed to support SMEs through loan schemes with a one-year moratorium and a two-year reimbursement period. The state contributed GH₵600 million (€85.8 million) to the scheme and partner banks contributed GH₵400 million (€57.2 million). At the end of August 12,000 individuals from all over the country had received a loan under this scheme. NBSSI also partnered with the Mastercard Foundation to launch a new support scheme (*Nkosuo*) for micro, small and medium-sized enterprises (MSMEs), including start-ups, in mid-September 2020. Mastercard Foundation committed GH₵90 million (€13 million) to offer grants and softs loans with similar conditions to the support give under CAP BuSS.[23] The other government-initiated scheme, the Coronavirus Alleviation and Revitalisation of Enterprises Support (CARES) was focused on building back after the pandemic. This scheme aimed to strengthen the national production capacity and the government pledged to acquire 50 percent of its procurement from Ghanaian enterprises in 2020 and to revitalise the private sector to decrease dependence on donor funds. The government anticipated that the private sector would contribute 70 percent of a fund of GH₵100 billion (€57.2 billion).

In Burkina Faso, the government issued an array of fiscal measures to support businesses, from waiving the collection of various taxes, payment deferrals or exemptions, and suspension or remission of penalties. After consultation with market traders in Ouagadougou, the government also covered the operating costs of the markets, secured stocks of consumer goods (sugar, milk, rice, oil, soap, etc.) and tightened price controls throughout the country. Early April, the government announced business support of 100 billion Fcfa (€152 million) but details of the Fonds de relance économique (FRE-COVID-19) only became public by mid-September, over five months after the initial announcement. In addition to subsidising the national airline, the scheme allocated a total of 30 billion Fcfa (€45.7 million) to support large enterprises; 40 billion Fcfa (€61.0 million) to SMEs; 20 billion Fcfa (€30.5 million) to very small enterprises, and 5 billion Fcfa (€7.6 million) to start-ups in 2020 and 2021.[24]

The FRE-COVID-19 scheme in Burkina only supports businesses that are formally registered, and it neglects paying attention to inclusivity. As a contrast the CAP BuSS scheme in Ghana proclaims its support for business owners who are female or who live with disability. However, its eligibility criteria exclude both the informal sector where more women (55.7%) operate than men (42.4%),[25] and the poorest who may not have the required tax identification numbers. The CAP BuSS has also been criticised for spreading its support too thinly to have any recovery effect. In general, the strategies and responses drawn up by the Burkinabe and Ghanaian governments have little focus on inclusivity. This is partly because the strategies and responses proposed are ad hoc in nature, even though the consequences of the measures potentially have long-term impact on the population.

Chapter 2. Advocacy and influence on policy and programming

It is difficult to determine the origin of the responses to the Covid-19 pandemic in both countries. Given the regular technical assistance from WHO in the West African region to contain outbreaks of infectious diseases such as meningitis, cholera, avian flu, and viral haemorrhagic fevers (e.g., Yellow fever, Ebola, Lassa fever), WHO's advice has shaped medical treatment and public health containment strategies. At the beginning of the pandemic, the WHO was a critical partner in developing preparedness and response plans. In Burkina Faso, the national WHO office was already well-staffed due to the complex humanitarian and security crisis and working closely with the Ministry of Health, hence the organisation is likely to have had significant influence on the Burkinabè strategies. The Africa Centres for Disease Control and Prevention (Africa CDC) used the African Union strategic lift capability to deploy 28 frontline responders from the Democratic Republic of Congo to Burkina Faso, Cameroon, Mali and Niger at the end of May.[26] While both strategic and practical in nature, the WHO and Africa CDC interventions promote a certain way of dealing with an epidemic and intimate that external help is indispensable in Burkina Faso.

From June onwards the WHO pushed the focus on to the need to maintain the continuity of health services for the most vulnerable populations.[27] In Ghana, the WHO has also advocated the need to maintain access to essential health services – reproductive, antenatal and child health - through its guidelines to healthcare professionals for safe and quality service delivery.[28] In Burkina Faso, professional organisations produced a guide to health care professionals of how to practice safely at the time of a pandemic.

ECOWAS and the West African Health Organization (WAHO) followed the same biomedical disease model, advising the 15 ECOWAS member states on how to prevent the spread of Covid-19 and supplying testing kits, specimen transportation kits and PPE. In an extraordinary session of heads of states and government on the 23 April, ECOWAS advocated that member states allocated at least 15 percent of their annual budget to strengthen their healthcare systems, as had been the recommendation since an extraordinary ECOWAS summit in November 2014 to respond to the Ebola epidemic. ECOWAS also advocated for states to deliver immediate humanitarian assistance to the poor and, in the longer run, to strengthen social protection by establishing social safety nets to support the most disadvantaged in society, to develop distance learning tools and to make internet access easy. Focusing on economic recovery, ECOWAS advocated significant spending to assist the private sector and especially SMEs through the financial sector, and the informal sector through microfinance institutions. As part of the economic recovery, ECOWAS pushed for states to reduce import reliance by supporting local production of consumer goods, including agricultural products, as well as of pharmaceutical and health protection equipment. Aware of the delicate national economy in several member states, the immediate effect of reduced tax revenues and other state receipts, ECOWAS recommended the mobilisation of additional financing from the international community.[29]

The strategic focus of ECOWAS recommendations is broad and somewhat vague with a low-key focus on targeting vulnerable groups, but without identifying particular categories of people and without promoting targeted inclusivity. While it is too early to assess whether Burkina Faso and Ghana will follow the recommendation of ECOWAS regarding public health spending, it is clear that both states prioritise strategies of a welfare state with a focus on formal businesses and, as we shall see below, a social protection system that assists vulnerable people. However, both states neglect targeted mitigation

responses to the vast number of people operating in the informal sector. The ECOWAS recommendations regarding continuity in education appear oblivious to the way that existing geographical, gender and class inequalities hamper distance learning in multiple ways that go beyond internet access.

While international and region-wide advocacy has shaped Covid-19 responses in both countries, the advocacy happening at the national level has been politicised to some extent. Both governments sought to demonstrate good governance internationally and nationally by responding proactively to the Africa CDC's epidemiological forecast that predicted a high rate of mortality due to Covid-19. The rapid containment response may have slowed down the development of the pandemic in both countries. However, the population, especially in Burkina Faso, has been dismissive of government containment strategies.

One of the reasons for this in Burkina Faso is the low infection rate, which means the health effects of the pandemic are imperceptible to most of the population. Moreover, the first cases of Covid-19 infection were members of the government and people from wealthy social classes, giving the impression among ordinary people that it was a problem affecting the elite only. This view was reinforced by a spike in Covid-19 cases in both Burkina Faso and Ghana after Christmas correlating with elite members of the diaspora visiting from Europe and North America. However, the fallout of government responses struck the majority hard and, as a result, non-state actors in Burkina Faso, from political parties to trade unions and civil society organisations have been successful in advocating dissent to government measures. The government was accused of blindly copying Covid-19 responses issued in France, as the closure of schools was decreed on 14 March, two days after the same measure was decided in France and the partial lockdown was imposed four days after France had adopted this measure. Another critique advocated the idea that the Burkinabè government used Covid-19 as a pretext to suppress opposition and union-organised challenges. The closure of educational institutions with effect from the 16 March was interpreted as a means of silencing strike action planned to start on that day among primary and secondary school teachers. This suspicion has been reinforced by the fact that the government vacillated a great deal before deciding to close places of worship and markets. The advocacy by the political opposition, unions and other significant civil society actors, as well as the recent history of mass protests that led to the fall of the long-serving president, Blaise Compaoré, facilitated a new wave of mass demonstrations organised by market traders, members of an association of Muslim practitioners and civil society. To appease the protesters, the government re-opened markets and places of worship and lifted the night curfew earlier than planned.

Although critiques have been voiced in Ghana as well, the support of the government's strategies has been more wide-ranging. The Ghanaian government appeared to be in a better position than its Burkinabè counterpart to sway critiques concerning unequal treatment, the amassing of power and potential misuse of legislative changes to normalise mass surveillance. The Private Sector Fund appears to have had a calming effect on some critiques. Early in the pandemic, differentiated treatment of international and local travellers sparked public outrage because the former were accommodated by the government while in quarantine and the latter were left to their own devices after being prevented from travelling home. The local travellers were predominantly labour migrants from the norther parts of the country who were out of work due to market closures and therefore had no income to pay for their daily meals and the public washroom and toilet facilities that they usually use. When public outrage surfaced, the Private Sector Fund intervened and served 144,000 meals to vulnerable people. This action advocated greater inclusivity in Covid-19 responses but also afforded the government time to devise a feeding project. Organisations such as the Tax Justice Coalition advocated for more focus on women's businesses in the government recovery schemes and the Peasants Farmers Association of Ghana

appealed for hedging part of the stimulus package to target smallholder farmers to improve agricultural production and to help improve food security. This advocacy impacted on the goal setting of the CAP BuSS but did not shape the design sufficiently to have gender sensitive eligibility criteria or to address the plight of rural populations.

Apart from ad hoc adaptations, the Ghanaian government has pushed policy strategies aimed at driving the government's Ghana Beyond Aid agenda, among others by supporting the local production of personal protective equipment with a US$10 million loan to some four companies in April. This strategy is in line with ECOWAS recommendations, though the Ghanaian government and leading business and banking executives may well have advocated an import-substitution agenda within the ECOWAS framework. To reach this goal, Ghana has mobilised a package of support from the UK government worth GH¢3.6 million (€518,850) to enable its pharmaceutical sector to adapt and build back better.[30]

In both countries, part of the election campaigns happened via social media to conform to Covid-19 containment measures, however, closer to election day, large political rallies were held by all candidates, often without social distancing and only partial use of face masks. While the media has reported on donations of PPE and handwashing facilities by political parties and thus has intimated that responses to the pandemic have been used in campaigning, a much more fine-grained analysis would be needed to analyse the extent and effect of such practices. Clearly the management of the pandemic has been part of political campaigning, by the government in office and the opposition. However, in Burkina Faso the conflict and security issues have had a more prominent place in the campaign than the Covid pandemic, but the criticism of and counter proposals to almost every intervention has made abundantly clear that the government works in a context of permanent challenge to its authority.

The government-led mitigation responses have mostly concentrated on economic poverty, but international actors have pushed a social protection agenda to address sexual and gender-based violence (SGBV). This agenda goes back a few years, the Covid-19 pandemic merely stimulated additional arguments about potential increases due to pressures of lockdown and economic instability. In Ghana, where 23.1 percent of women experienced gender-based abuse in 2015, the Covid-19 containment measures prompted UNFPA, Plan-Ghana and Vodafone to support the Ghanaian Domestic Violence Victims Support Unit by financing a telephone hotline, an information campaign to increase women's and girls' access to Sexual and Reproductive Health Rights, and a special unit to isolate women with Covid who had been subjected to abuse before resettling them in a safe centre.

In Burkina Faso, the government does not appear to prioritise protection against gender-based violence (GBV). A household survey undertaken on behalf of the Ministry of Economy and Finance in 2011 showed that although 20 percent of women had experienced physical violence at some point in their life since the age of 15, only 9.3 percent had been subjected to gender-based abuse in the previous year.[31] However, programming to prevent GBV and support women has been part of the international humanitarian responses to conflict and insecurity in Burkina Faso since 2017, and the pandemic motivated calls from UNFPA and OXFAM to support their on-going work with additional funding due to fears that night curfews to contain Covid-19 and rising food prices would aggravate the risks of GBV.[32]

Programming linking Covid-19 and SGBV have not received much attention in the national media. With the given data, published primarily by international organisations, it is difficult to assess in this paper the full range of actors driving inclusivity in the measures focusing on women's and girls' sexual and reproductive rights.

Finally, the pandemic has not shifted power relations much in terms of cooperation. In both countries, Covid-19 is perceived by ordinary people as a disease of the powerful, of those working indoors in air-conditioned settings and of those circulating between transnational spaces. Preventive measures and mitigation programmes signal momentous efforts among the powerful to resolve the problem technically and financially, proving their capacity to do so to ordinary people but also their negligence to implement similar efforts when dealing with more mundane illnesses, which affect many more people.

The different economic positions of Burkina Faso and Ghana are reflected in their relationships with international humanitarian and development actors. The view on Burkina Faso among international donors and implementing organisations as incapable of addressing a pandemic and the influence they wield on policies and programming do not suggest any change in power relations. The stronger economy in Ghana coupled with politics to make the country less dependent on aid suggest a different type of relationship with international organisations but the implication of the World Bank in the LEAP programme, Mastercard Foundation in education and business programmes, UNFPA and Oxfam in SGBV programmes bring to light spaces for continued global influences. To unpick the relationships between the different actors and the changes that might have happened within these spaces of influence would require an institutional ethnography. Data based on national news outlets and reports released by the implementing organisations or the state offer insufficient insights for such an analysis.

Chapter 3. The impact on vulnerable populations of policy and programming during the pandemic

The fallout from market closures, partial lockdowns and night curfews affected poor families in the large cities immediately because they were barred from doing their portfolio of livelihood activities, but the effect quickly spread to other parts of the countries as food prices rose. School closures further affected those children in receipt of feeding programmes at their schools. In Ghana, around 2.1 million children (the number of recipients in 2018) lost out on a nutritious meal a day and would need feeding at home. To address the increased vulnerability of poor families, adaptations were made to the World Bank supported social safety net programmes in both countries.

In Burkina Faso, the programme *Burkin Naong-Sa Ya* (end of misery in Burkina Faso) has provided cash transfers of around 10,000 Fcfa (€14) per month to poor or vulnerable households since 2014. To relieve the beneficiaries in the big cities, who were adversely affected by the Covid-19 containment measures, the programme doubled the assistance to 43,000 beneficiaries in Ouagadougou and Bobo-Dioulasso for the months of May, June and July. The effects of rising prices on rural populations were not considered.

In Ghana, the Livelihood Empowerment Against Poverty (LEAP) programme has provided cash transfers and health insurance to poor and destitute families; guardians of orphaned and vulnerable children; persons with severe disability; destitute pregnant women; and elderly persons over 65 years of age, since 2018. By 2020 LEAP supported around 332,000 households across all of Ghana, though with a larger proportion of beneficiaries living in the north. Cash received by households ranges from GH¢32 to GH¢53 (€4.58 to €7.58) per month. To alleviate the additional hardship resulting from Covid-19 for LEAP beneficiaries, changes to the cash transfer structure were made to pay in advance instead of in arrears, resulting in a one-off larger payment to offset the rising costs of living. An additional sum of GH¢ 10 (€ 1.43) was granted to enable beneficiaries to purchase masks and other items to maintain a high level of hygiene. Moreover, transfers were made using a digital platform to ease access. However, this shift may have disadvantaged female recipients if the gendered pattern of digital money platform use was the same in 2020 as in 2017 when only 34 percent of women compared to 44 percent of men had mobile accounts.[33]

Both governments failed to properly assess the inclusivity of their mitigation and recovery strategies. However, civil society organisations (NGOs, professional associations, faith-based organisations, and other actors) initiated micro-actions or financial support on multiple occasions. In Burkina Faso, where government actions were subject to much criticism nationally, international organisations and CSOs complemented the government by supporting vulnerable people that were not specifically targeted by the government. Examples of support include food donations worth more than 23 million Fcfa (€35,000) from the Islamic Educational, Scientific and Cultural Organization (ISESCO) to internally displaced persons and people living in crisis zones; PPE and awareness-raising material worth more than 54 million Fcfa (€82,000) from the NGO Solidar Suisse to displaced persons and children outside the school system; food and protective equipment worth 10 million Fcfa (€15,000) from the German group SysAid to an orphanage; food and protective equipment worth more than 2 million Fcfa (€3,000) from the Assemblies of God Church to the women of the Green Brigade (street cleaners) in Ouagadougou; and modest donations of protective equipment to unspecified recipients from the diaspora. This support adhered to the medical model of disease control and to traditional humanitarian assistance.

In Ghana, the government received much support from the private sector, and especially the Covid-19 Private Sector Fund, which, as mentioned above, acted as a gap-stopper feeding female migrant workers from the northern part of Ghana, when they could not return home. An existing programme organised by the Ghanaian Springboard Road Show Foundation with funding from the Mastercard Foundation and Solidaridad, which has delivered a weekly virtual university on Ghanaian Radio for the past decade, extended its reach to help young people in coping with the fallout of the pandemic through online mentoring, coaching and counselling between June and November 2020. Numerous NGOs working with vulnerable people raised additional resources to contribute to food security. Just below 10 percent of households received some assistance from an institution during lockdown, mostly food for a value of roughly GH¢50 (€7). Although the Ghanaian government emphasised support of women and people with disability in its design of the CAP BuSS scheme, despite the good intentions, the eligibility criteria for support undermined the goals of the programme. However, the Ministry for Business Development implemented a programme with a budget of GH¢2 million (€285,133) that targeted businesspeople with disabilities and aimed to support them expand their businesses, but only in fashion, agriculture, commerce, food and beverages.

The many actors working with disadvantaged and vulnerable groups and gap-stopping lacunas in government-led programming results in a diverse set of interventions with no overall strategy. The potential exclusion of certain groups is obscured in this mosaic of interventions and would require a focused review of evaluation reports of the range of interventions implemented in each country.

Chapter 4. Public communication strategies

In both countries, the main channels for the politicians and the state to communicate policies and decrees were television and radio news, as well as print and online media. Much effort went into communication to ensure the population being well-informed, to strive for clarity and to give an impression of accountability. In the early days of the pandemic, both presidents regularly made televised speeches to announce the decisions taken in relation to the pandemic, or to explain them.

In Burkina Faso, the Government Information Service called on members of the government or the national coordinator of the Covid-19 response to hold daily press briefings between the 18 and 27 March and thereafter once a week. Additionally, it published daily statistics on the state of Covid-19 infections, hospitalisation and deaths in Burkina Faso. In response to the repeated challenges of government actions, the High Council for Social Dialogue 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 and the development of palliative measures that would be acceptable to the population.

In Ghana, updates were provided once a week, usually Sunday evenings. For the literate, wealthier population, information was available online in English on various platforms including a daily update available on a WhatsApp platform managed by the Ministry of Communication. Lower income populations without English language skills did not have as much access to the general information published by the government regarding the pandemic. In the beginning, the presidential addresses were in English and while a sign language interpreter ensured that the hearing-impaired population could access the information immediately, the non-English speaking population had to wait until the following day, when the Minister for Communication went on air with a translation into Akan. Later in the pandemic, the president addressed the population in English, Akan and Ga. While this adaptation was an attempt to include the largest language groups, many smaller languages were left out. Civil society filled this lacuna from the beginning. A range of non-state actors developed and disseminated information about Covid-19 to raise awareness of modes of transmission, symptoms and safety protocols to avoid infection and of measures implemented by the state. Farmerline played an important role in translating information material into several languages and disseminating it to several language groups across rural Ghana. Vodafone Foundation runs a telecentre with medical and healthcare information in the most spoken Ghanaian languages as well as a few other languages, and the Covid-19 Private Sector Fund worked with several professional organisations to counter stigmatisation of those infected. CSOs have thus been crucial in extending information to a much wider segment of the population.

Chapter 5. Innovations emerging from Covid-19 responses

One innovation observed in both countries is the governments appeal to the private sector to support their treatment and containment responses to the pandemic. Many companies rose to the challenge and produced an impressive range of products during this period including hand sanitisers, face masks, and personal protective gowns. In Ghana, companies have designed and produced different kinds of hand washing stations, including solar powered ones, and in Burkina Faso the International Institute for Water and Environmental Engineering (2iE) received support from the African Development Bank to produce face masks and shields using 3D printing technology and recycled plastic, as well as hydro-alcoholic hand sanitisers.[34]

In Ghana, the delivery of Covid-19 testing samples from both urban and rural health facilities to the central laboratories was sped up by using drones supplied by a California-based start-up. The company expects to operate this new daily service for the duration of the government's Covid-19 response efforts, marking the first time in history that autonomous drones have been used to make regular long-range deliveries into densely populated urban areas. The new delivery service allows the government to monitor more closely and respond to the spread of the disease in some of the most remote areas.

The medical and pharmaceutical sector in Burkina Faso engaged with support from the Ministry of Research in clinical trials of chloroquine and a plant-based drug, Apirivine, to identify a treatment for Covid-19. This programme stemmed both from the desire to position Burkina Faso internationally in the debate on the effectiveness of chloroquine, and from the desire to contribute to the fight against the pandemic. Moreover, a proven effect of chloroquine or a remedy derived from local plants would have enabled African states to benefit from low-cost treatment of the disease. However, it is interesting that out of all its efforts to mobilise international donor funding, in this area Burkina Faso was unsuccessful. Recollecting the perceptions of the Burkinabè public health system at the beginning of the pandemic, funding was granted to projects directly impacting on healthcare provision and to mitigation of the economic and social fallout of the pandemic. It is likely that priorities that were not strictly on the immediate well-being of the population were not perceived in the international community to be credible or desirable.

At the political level, we have not observed any innovation but, as noted above, the methodology adopted in the studies is not appropriate for detecting subtle changes, nor has it been possible within the given time frame and scope of the study to collect sufficient background material to gauge possible changes in the full range of areas targeted by Covid-related measures.

Conclusion

The synthesis of the two country studies crystalises the global influence of the biomedical disease model on how countries respond to a new epidemic. Undoubtedly, the response to Ebola and to recurrent epidemics of cholera and meningitis in both countries and the WHO's capacity to respond rapidly to new crises have persuaded West African governments to pursue the advice given by WHO. The rapid response in both countries may have slowed down the spread of Covid-19. However, the difference in the epidemiological development between the two countries may also offer a window on how class impacts on disease transmission. The fact that the first cases in Burkina Faso belonged to the country's elite may have been a contributory factor in slowing the spread of Covid- 19 since they often socialise in exclusive circles. Had the Burkinabè government made a critical assessment of the risk of spread given the social dynamics, it would probably have been dismissed due to the dominant view among global actors on the incompetency of the public health system, but it might also have been dismissed due to the power of the biomedical disease model. However, the measures taken in Burkina Faso seemed like swatting mosquitoes with a sledgehammer given the low levels of infection.

The discrepancy between the national economies and further the dependence in Burkina Faso on humanitarian crisis responses to the conflict and insecurity that has engulfed the north and the east of the country were the factors producing the most pronounced impact on who were involved in shaping Covid-19 responses. Burkina Faso was very dependent on international donors and technical partners and although we have not been able to analyse possible conditionalities in grants allocated to Burkina Faso, we argue that it is more difficult to diverge from global ideas of how best to address a pandemic with such heavy dependence. In comparison, the Ghanaian government was dependent on the private sector for partial funding and would thus have to tailor recovery strategies to this sector's benefit, if it were to depend on its support in the future.

Both governments used very broad and 'inclusive' definitions of who was deemed vulnerable, drawing on the social safety nets' identification of vulnerable groups for targeted economic assistance but otherwise leaving the categories so vague that they were ineffective. As a result, mitigation measures ended up supporting a much larger group of people and not always those most in need. The means-based subsidies in Burkina Faso did, however, target the poorer households better than the subsidies offered in Ghana, although they still ignored the existing inequalities in service provision. The many civil society actors involved in support of disadvantaged and vulnerable groups to cover areas disregarded by government interventions obscured potential exclusion of certain groups.

Endnotes

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[7] One example of such information effort is a webinar hosted by the alumni association of Wesley Girls' High School, https://www.youtube.com/watch?v=0UMH11M_RP0. A number of Ghanaian professionals have also come together in a WhatsApp group called *Stop Coronavirus* to combine their skills to fundraise and develop information. Of the 46 members, 9 members are transnational migrants in the US and the UK.

[8] The work of diaspora associations in North America intimates their multiple concerns; in New York, support was aimed at the most vulnerable members of the diaspora community (https://lefaso.net/spip.php?article96603), while in Canada, fund raising was aimed at Burkina Faso, with a choice to support vulnerable people or the state. The target sum was CAN$35,000 (€23,420) (https://lefaso.net/spip.php?article96519).

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