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## Residual capacity and the political economy of pandemic response in Ghana

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WIDER Working Paper 2022/44

# **Residual capacity and the political economy of pandemic response in Ghana**

Kofi Takyi Asante\*

April 2022

**Abstract:** On the whole, poor countries in Africa and elsewhere seem to have weathered the coronavirus (SARS-CoV-2, or COVID-19) pandemic better than wealthier countries with superior healthcare systems. Using the Ghanaian case, this paper draws on newspaper articles, policy statements, and other secondary sources to explain how the country's competitive clientelist political settlement mediated the public health outcomes of the pandemic. It argues that while it lacks overall state capacity, Ghana was able to surmount the limitations of its weak and under-resourced public health system by leveraging 'residual capacity' from previous public health programmes and a strong proactive response from the continental and subregional organizations. The government's strong early response enabled it to gain control of the situation in the crucial first few months of the outbreak. However, with an upcoming election later in the year and unwilling to bear the political costs of sustaining its initial efforts, the government subsequently wavered in its response. The country's infection and death rates spiked and dipped in response to these waves of enforcement. The paper concludes with a brief discussion of the limits of 'residual capacity' in public service delivery.

**Key words:** COVID-19, state capacity, competitive clientelism, political settlements, Ghana, public health

**JEL classification:** H40, I15, P16

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## 1 Introduction: the political lives of pandemics

On the whole, poor African countries weathered the first year of the coronavirus (SARS-CoV-2, or COVID-19) pandemic much better than could be expected from the low capacity of their health systems. They avoided the overwhelming numbers of cases and deaths that were recorded in other world regions (see Appendix A, Figures A1 and A2). At the outset of the pandemic, there were fears of catastrophic outcomes for the continent's health systems (Lone and Ahmad 2020; Nepomnyashchiy et al. 2020; Paintsil 2020), including the infamous predictions, based on events in Ecuador, of apocalyptic scenes of corpse-strewn streets.<sup>1</sup> The pessimism about Africa's ability to withstand the pandemic was well founded given the weak state of health systems across the continent (Martinez-Alvarez et al. 2020; Paintsil 2020), making the relatively mild overall impact of the pandemic on African health systems a matter of scholarly (Chitungo et al. 2020) and journalistic (Soy 2020) interest. While no definitive answer has yet emerged, what is clear is that any adequate explanation of the cross-national variations in health outcomes will need to address the political economy of public health emergency preparedness and response.

In particular, it is important to recognize that public health emergencies, much like any other crisis, have a political life (Chigudu 2020). A crisis involves 'a situation that threatens significant harm to a country's population or basic social values and compels a political response under time pressure and uncertainty', but the politics of crisis statecraft bears many similarities to politics in relatively more settled times (Lipsky 2020: E99). Much like policy-making in settled times, crisis statecraft is subject to political contestations because crisis response policies create winners and losers and can be a source of rent (Ali et al. 2021; Quartey and Asante 2021). And while crises can impose heavy social and political costs, no disaster is too devastating to be converted into political capital: canny politicians have used such occasions as opportunities to 'muster strong political and societal support for ... drastic measures' and to bestow 'leader-focused patriotism' on otherwise beleaguered politicians (Boin and Hart 2003: 1–2; Klein 2007).

This paper examines the institutional and political contexts of Ghana's preparedness for and response to COVID-19. It contributes to an emerging body of work that looks beyond aggregate outcomes to investigate the correlation between capacity and pandemic outcomes. For instance, Gisselquist and Vaccaro (2021: 2) find that after controlling for relevant factors such as population age structure, we can actually observe the '(expected) inverse relationship between state effectiveness and pandemic health outcomes'. Similarly, a study published in the *Lancet* found that the mortality rate among critically ill COVID-19 patients in Africa who needed intensive care was much higher than for similar patients in other parts of the world, including Asia and South America, due to factors including the lack of critical care facilities (Biccard et al. 2021).

A focus on the political economy of pandemic response is important for many reasons. First, this approach fits into an established literature on the role of the state in development. This literature attributes a determinative role to the state in national development. Second, while the epidemiological and medical know-how needed to combat the pandemic are matters of professional expertise, questions of how this expertise is implemented and the capabilities of the health sector in which it is embedded are not immune to politics. In fact, the political salience of public health means that public health emergencies like COVID-19 are likely to become matters of political contestation.

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<sup>1</sup> For a critical summary of these predictions, see Okereke and Nielsen (2020)

A political economy perspective further draws attention to an oft-overlooked fact: that states do not exist in isolation (Magubane 2005). The line dividing domestic and foreign policy is blurry, as international commitments and alliances shape domestic policies. Moreover, unique geopolitical configurations at any point in time create opportunities as well as constraints for domestic state action. Accordingly, this analysis places Ghana's pandemic response in the context of the early measures put in place at the continental and subregional levels. Although the country's health system has serious weaknesses—including poor infrastructure, inadequate funding, and lack of critical health facilities—which placed Ghana at a marked disadvantage at the onset of the pandemic, it benefited from proactive coordination by the African Union (AU) and the Economic Community of West African States (ECOWAS). In addition, Ghana and other West African countries were able to leverage 'residual capacity' that had developed from public health initiatives like polio immunization campaigns and the measures put in place during the Ebola outbreak in 2014. These past interventions had set up an infrastructural and institutional basis that helped in the rolling out of Ghana's response.

In this paper, I argue that while it lacked core state capacity, Ghana was able to leverage the proactive (sub)regional coordinated response and the residual capacity built from previous public health programmes to overcome the limitations of its weak and under-resourced public health system. Building on this foundation, the government's strong early response allowed it to gain control of the situation in the crucial first few months of the outbreak. However, given the high political and economic cost of sustaining these measures and with a general election approaching, enforcement of the public health measures became sporadic. The country's infection and hospitalization rates spiked and dipped in response to these waves of enforcement.

The rest of the paper proceeds as follows. The next section critically reviews the literature on state capacity and the politics of state effectiveness in Ghana. The third section provides an overview of the capacity of Ghana's public health system, while the fourth describes the coordinated efforts at the African and West African levels to build preparedness against the pandemic. The fifth section analyses the government's response to the COVID-19 outbreak in Ghana. The paper concludes with a brief discussion of the politics of pandemic response and the concept of residual capacity. The analysis draws on a variety of secondary data sources, including statistics on COVID-19 infections and deaths, reports on health system capabilities, official policy statements, and media accounts of the outbreak and government responses.

## **2 The concept of state capacity: analytical utility and potential pitfalls**

The concept of state capacity is a useful analytical construct for understanding states' ability to effectively discharge functions and to ultimately drive economic development. Peter Morgan (2006: 8) defines the concept as 'that emergent combination of attributes that enable a human system to create developmental value'. The concept analytically draws on insights from the political sociology of the state (Williams 2021), and in particular on the notion of 'infrastructural power', which Michael Mann (1984: 198) defines as 'the capacity of the state to actually penetrate civil society, and to implement logistically political decisions throughout the realm'.

While the concept can aid our understanding of state performance, its analytical utility is undermined by an incoherence in usage that impedes 'communication and shared learning' (Morgan, 2006: 2). The concept's lack of analytical clarity partly derives from the disconnect between its origin in macro-historical studies and its current predominance in micro-level case studies of bureaucratic effectiveness (Williams 2021). Second, there are two related but analytically distinct phenomena to which the concept may refer; namely, capacity as *process* and capacity as

*outcome* (Morgan, 2006: 17). Relatedly, and perhaps more consequentially, there is an assumption of a correspondence between states possessing the right configuration of factors to generate capacity and the actual manifestation of capacity. In actual fact, the gulf between ‘potential and action’ (Williams 2021: 342) tends to be wide, because politics always mediates the actualization of capacity.

In cross-national comparisons of bureaucratic performance, it is assumed that capacity is located exclusively within the state. However, state capacity can be enhanced or undermined by exogenous factors at the regional or even geopolitical levels. As the response of Ghana and other African states shows, capacity—defined as the ability to implement policies or more specifically, to achieve a certain policy end—can bypass structural national weaknesses or defects.

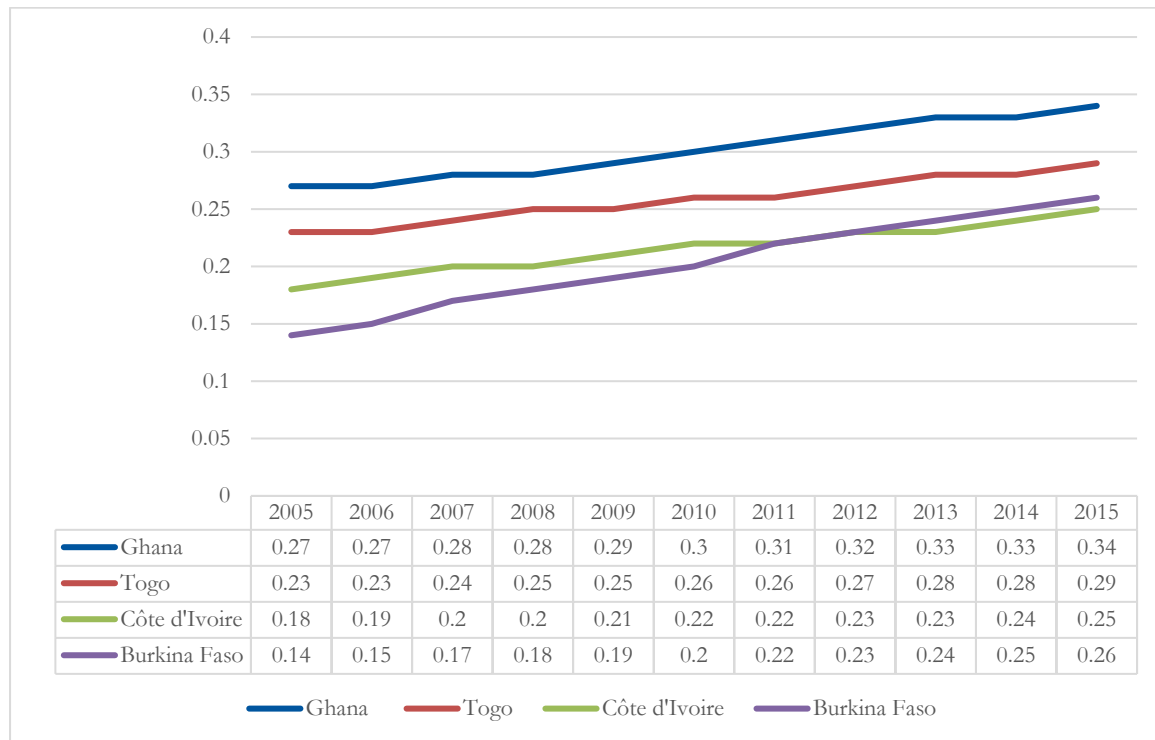
When used as an independent variable in cross-national studies, there is an assumption that the level of capacity is homogeneous across all relevant sectors of the state. However, given that the state performs multiple functions—including maintenance of its territorial integrity, ensuring its monopoly over domestic use of legitimate violence, delivering infrastructure, and nurturing economic development, among others—and that it has ‘many hands’ (Morgan and Orloff, 2017) that perform these various functions, it is reasonable to expect that capacity will be unevenly distributed across the various sectors of the state. This is especially the case in poor countries, where in the midst of overall state weakness or underperformance, some sectors stand out as strong performers.

## **2.1 The politics of state capacity in Ghana**

Despite its reputation as an island of peace and prosperity in an otherwise turbulent region (Aryeetey and Baah-Boateng 2016; Ateku 2017), there is broad consensus among scholars of the Ghanaian state that its overall capacity is substandard (Ansu 2013; Resnick 2019), a weakness often attributed to its having a ‘public administration system that does not work and which severely reduces the ability of the government to implement reforms and programs’ (Whitfield 2010: 735). Weak public sector management, in turn, undermines policy coordination ‘which [could] help determine whether there are large gaps between policy formulation and implementation’ (Resnick 2019: 72), resulting in a vicious cycle of eroding public sector effectiveness. Over the past few decades, Ghana’s governance profile has shown declining performance on measures of public sector management and infrastructure provision while performing strongly on indicators of democratic quality. Drawing on data from the Mo Ibrahim Index of African Governance (IIAG), which ranges from 0 to 100, Resnick (2019) shows that between the year 2000 and 2014, Ghana’s quality of public sector management actually declined from 48.9 to 45.1, and it was one of only two countries among a selection of Sub-Saharan African (SSA) states—the other being South Africa—that experienced a decline.

The state capacity dataset compiled by the German Development Institute (DIE) rates Ghana’s capacity as low, with a score of 0.34 out of a possible maximum score of 1. Ghana’s capacity rose over the ten-year period covered by the DIE dataset, but the rate of improvement was unimpressive, increasing only by 0.07 between 2005 and 2015. Ghana’s low rating is reflective of the generally poor performance across the African continent. However, Ghana outperformed its immediate neighbours, which also saw marginal improvement in their level of capacity in the decade since 2005. In 2015, Côte d’Ivoire was the lowest performer among Ghana’s neighbours (see Figure 1).

Figure 1: Historical trends in capacity levels: Ghana, Togo, Burkina Faso, Côte d'Ivoire



Source: author's illustration based on data from Grävingholt et. al. (2018).

The state of Ghana's capacity should be understood within the context of broad economic and political transformations of the past few decades. Since the 1980s when sweeping economic reforms were introduced as part of the Bretton Woods-led structural adjustment policies (SAPs), Ghana has abandoned interventionist policies for a market-driven strategy 'in which the government focuse[s] primarily on creating an enabling environment' rather than actively promoting or nurturing particular sectors (Diao et al., 2019: 6). Ghana has since achieved strong economic growth, but this has not been driven by and has not led to structural transformation of the national economy (Diao et al. 2019; Whitfield 2011). Activist governments are necessary to foster structural transformation (Resnick 2019), but given the abandonment of interventionist policies, 'some areas of the economy that are fraught with market failure problems have remained underdeveloped, and this has contributed to the limited growth of higher productivity sectors, and hence the low gains in productivity growth from structural change' (Diao et al. 2019: 8).

The second aspect of this transformation is the introduction of multi-party politics with the promulgation of the Fourth Republican constitution of 1992. Consistent with theoretical expectations (Khan 2005), the pressures of competitive politics have yielded broad human development dividends. Electoral pressures forced the Ghanaian state to respond to the needs of citizens, but political liberalization has also led to the proliferation of interest groups making demands on the state (Boafo-Arthur 1999). Confronted with a weak economy where the industrial base is minuscule in comparison with the informal sector, political elites feel compelled to resort to short-term policy options, including the distribution of highly visible public goods (Appiah and Abdulai 2017; Asante 2021; Asante and Mullard 2021).

This results in a competitive clientelist political system where the alternation of political power in free and fair elections occurs alongside entrenched patronage politics (Asante and Khisa 2019; Oduro et al. 2014). Under competitive clientelism, democracy could be said to have 'become hostage to interest group pressures' where governments are motivated to sideline potentially

beneficial policies if these would involve prioritizing the interests of an electorally marginal group over those of a larger or more powerful constituency (Resnick 2019: 54).

Competitive clientelism has undermined attempts to foster bureaucratically effective public agencies in Ghana (Appiah and Abdulai 2017). Abdulai (2021) attributes this to Ghana's peculiar political settlement dynamics, namely the dispersal of power between two dominant political parties—the National Democratic Congress (NDC) and the New Patriotic Party (NPP)—and the internal fragmentation within these parties. Thus, political elites resort to ultimately self-sabotaging tactics involving 'short-term political survival strategies ... that undermine the capacity of the state bureaucracy, including politically-motivated changes in senior bureaucrats during election turnovers' (Abdulai 2021: 7). The frequent turnover of technocrats in the civil service 'undermines professionalism, continuity, long-term planning orientation, learning and innovation in the public service' (Ansu 2013: 512). This overall structural context shapes the performance of Ghana's public health system.

### **3 The capacity for healthcare delivery in Ghana**

Ghana's healthcare delivery has improved over the years but at a very slow pace, and the sector's performance has generally been underwhelming (Abdulai 2018). In a recent study, the performance of the Ministry of Health was rated by experts as below average and far behind that of other ministries such as Finance and Foreign Affairs (Abdulai 2021). Available statistics on public health delivery in the country paints a grim picture.

Emergency healthcare delivery shows several points of weakness, although attempts have been made in recent years to address some of the most egregious ones. The National Ambulance Service (NAS), established in 2004, had 133 stations across the country by December 2017. However, only 45 of these ambulance stations were functional, and vehicle availability at the functional stations stood at 50 per cent owing to frequent breakdowns and inadequate funds for continual maintenance of the fleet (MoH 2018: 12). In 2018, there were only 55 functioning ambulances for the entire country (ISSER 2019).

In 2019, the government fortuitously procured 307 ambulances to replenish the existing stock, which were then distributed to the various districts, regional, and teaching hospitals in January 2020, two months before the country recorded its first cases of COVID-19 (ISSER 2020). With these new acquisitions, the NAS now has 362 functioning ambulances and 180 ambulance service stations, while additional emergency medical technicians (EMTs) as well as allied and administrative staff have been recruited and trained (Owusu and Asante 2020). Nevertheless, poor infrastructure is an obstacle to equitable access to healthcare, especially in remote parts of the country where roads in a state of disrepair 'pose threats to stable patient management, timely scene response, and the longevity of the ambulances' (Owusu and Asante 2020: 2).

Another issue militating against timely response to health emergencies is shortage of beds, which leads to health facilities turning away patients needing urgent medical attention. Commonly referred to as 'no-bed syndrome', this problem has triggered multiple national controversies after bereaved relatives have taken to social media to vent their grievances due to their inability to find a hospital willing to take in the sick (ISSER 2019). However, a publication by the Institute of Statistical, Social, and Economic Research at the University of Ghana suggests that it was a 'lack of proper direction in Ghana's healthcare system, rather than the absence of beds for emergency admission', that lay at the root of the problem (ISSER 2019: 60). In fact, the report points out that between 2013 and 2016, about 40 per cent of all beds nationally were unoccupied. That

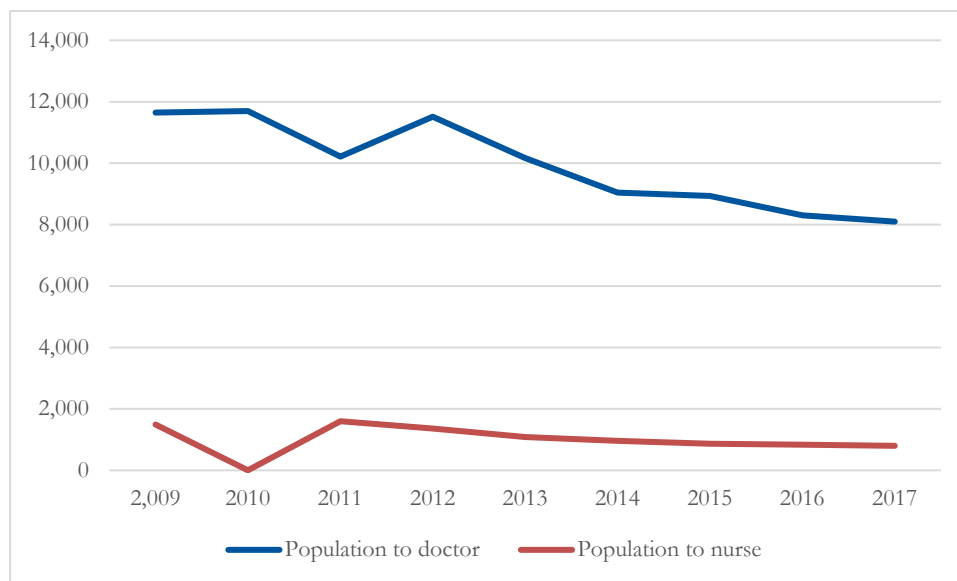


notwithstanding, in response to the backlash, the management of public health facilities took steps to increase the number of beds in Accra, where the problem had been particularly acute (Owusu and Asante 2020).

To address some of the remaining structural impediments to health delivery, recent interventions have sought to leverage technological innovations to improve access to healthcare across the country. The most noteworthy of these was a collaboration between the Ghana Health Service and Zipline in 2019 to use drones to deliver medical supplies to remote parts of the country. The director general of the Ghana Health Service at the time, Dr Anthony Nsiah-Asare, was optimistic that the innovation would help the country ‘save money and save lives’ (GhanaWeb, 2019). This turned out to be a timely investment, as the drone delivery system was quickly incorporated into the country’s national COVID-19 response strategy.<sup>2</sup> However, the infrastructural deficit and inequitable distribution of health facilities which necessitated the use of drone delivery in the first place remain and require long-term planning and investment, which is undermined by the country’s competitive clientelist political settlement.

Similarly, the ratios of population to health professionals are low but have seen slow improvements in recent years. The ratio of population to doctor has dropped steadily from 11,649 people to a doctor in 2009 to 8,098 people to a doctor in 2017. The ratio similarly improved for nurses, dropping from 1,494 in 2009 to 799 in 2017 (see Figure 2). However, this still puts Ghana behind its African peers. In a recent World Bank survey, Ghana placed 14th in SSA in doctor-to-patient ratio and 4th in West Africa (Pulse Ghana 2020).

Figure 2: Ratio of population to health professional ratio, 2009–17



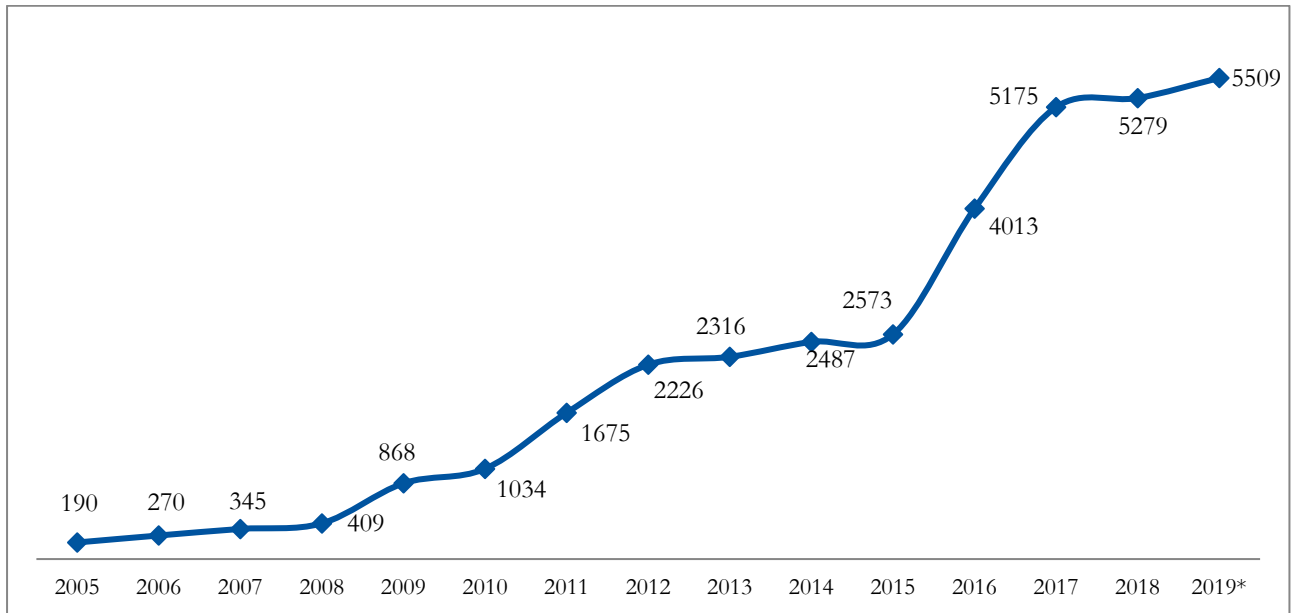
Source: author's illustration based on data from Abdulai (2018) and MoH (2018).

To address disparities in access to health infrastructure, Community-based Health Planning and Services (CHPS) policy was introduced in 2000 as a service ‘where Community Health Officers (CHOs) are engaged to live in compounds provided by the community or the District Assembly. The primary function of CHOs is to deliver basic healthcare to the doorsteps of individuals within the selected communities, in addition to making prompt referrals, when necessary’ (ISSER

<sup>2</sup> In April 2020, drone delivery of COVID-19 test samples began in Accra and Kumasi; and in March 2021, Ghana became the first country in the world to use drones to deliver COVID-19 vaccines (León 2020; Nwannekanma 2021; Vincent 2021).

2020: 194). In the implementation of the CHPS concept, ‘a partnership is developed with the community leaders and members in a bid to come to a general consensus on the needs of the community thereby forging a feeling of ownership of the initiative within the community’ (Nwameme et al. 2018: 2). Since its introduction, the number of functional CHPS zones have grown exponentially from 190 in 2005 to 5,509 in 2019 (see Figure 3).

Figure 3: Number of functional CHPS zones, 2005–19



Note: \*provisional estimates

Source: author’s illustration based on ISSER (2020).

In spite of these improvements, the health sector is still plagued by serious structural constraints. For instance, even though the ratio of health personnel to population is improving, there is a longstanding problem of health worker shortage, especially in rural areas (Okyere 2018).<sup>3</sup> Additionally, resources to improve ‘healthcare access are unequally distributed, with the poorer regions in the north having the poorest health status’ (Asante and Zwi 2009: 372). Just like in other sectors of the economy (Abdulai and Hickey 2016; Banful 2011a, b), the disbursement of funds to health facilities does not follow the proposed formula. Instead, allocations are ‘influenced by factors ranging from the availability of human resources for health, local capacity to utilize funds, involvement of donors in the health sector, and the political and administrative commitments to promote equity’ (Asante and Zwi 2009: 376). Delays in the release of public sector health funds to districts also affects service delivery across the country. In some cases, the first of what should have been quarterly disbursements are only received in last quarter of the year (Asante et al. 2006; Asante and Zwi 2009).

With regard to facilities necessary for treatment of COVID-19 patients, the situation is even more dire. A recent study found that in February 2020, there were only 16 operational intensive care unit (ICU) beds across nine institutions in the country. Additionally, there was a severe deficit in

<sup>3</sup> Some administrators try to manage the situation by resorting to a number of strategies, including providing incentive packages or practising task-shifting, but prior training is not always provided before new or additional tasks are assigned, and incentives packages are often not attractive enough to workers (Okyere 2018).

the country's critical care bed capacity, with 0.5 ICU beds per 100,000 people (Siaw-Frimpong et al. 2021).

The longstanding problems affecting healthcare delivery in the country as well as the improvements that have been recorded over the past few decades can be traced to the unique configuration of forces that structure the prevailing competitive clientelist political system. As discussed above, political leaders in the country are reluctant to adopt or follow through with politically costly but necessary policy choices aimed at improving the effectiveness of various state agencies or sectors. At the same time, they feel compelled to prioritize highly visible distributive policies that could court voters (Banful 2011b), especially if these also provide opportunities for extractive corruption (Asante 2021; K.T. Asante and Mullard 2021).

This competitive clientelist logic is manifested in the tendency to prioritize the building of large hospitals in urban areas rather than clinics or CHPS compounds in small towns and villages (Asante and Zwi 2009). Ironically, the implementation of the CHPS programme itself has focused more on building than on equipping the compounds. Between 2002 and 2014, the number of CHPS compounds increased from 39 to 2,948, but a 2010 review found that over half of them were not staffed with the requisite health personnel (Abdulai 2018: 16).

#### **4 Regional and subregional responses**

Wary of the likelihood that a large outbreak might lead to the collapse of fragile national health systems, the continental and subregional bodies launched a flurry of activities in the first three months of 2020 to build preparedness (Ahanhanzo et al. 2021). These preparations were absolutely essential given the decrepit nature of many national healthcare systems. In fact, health systems across Africa have long suffered neglect, with the personnel and facilities needed to fight the pandemic sorely lacking. For instance, there were only 2,000 ventilators across 41 African countries and 5,000 intensive care beds across 43 countries. At the same time, the doctor-to-patient ratio in SSA was 0.2 per 1,000, compared with 2.6 in North America, 3.7 in the European Union (EU), and a global average of 1.6: a shortage the Africa Centres for Disease Control (Africa CDC) describes as 'catastrophic' (Wadvalla 2020: 1).

In spite of the lack of overall or 'core capacity' of individual African countries to effectively meet the challenge posed by the pandemic, coordination at the regional and subregional levels helped countries to prepare for and mitigate the impact of the domestic outbreaks. The Africa CDC 'activated its Emergency Operations Center for COVID-19 on 27 January 2020 after at least four Asian countries had announced cases', and began holding virtual coordination meetings weekly with its Regional Collaborating Centres and with national health institutions; and a system was developed across all five AU regions to verify national alerts and reports (Loembé et al. 2020: 1,000). By quickly leveraging this pre-existing operational capacity, the Africa CDC was able to assist member countries with weak health systems to strengthen their preparedness for the outbreak.

The late arrival of the virus on the continent also provided the Africa CDC with:

a window of opportunity to rapidly mobilize a continent-wide response. An emergency meeting of African health ministers held on 22 February [2020] led to the adoption of the Africa Joint Continental Strategy for COVID-19. The strategy was approved by the Bureau of the Assembly of AU Heads of States and Government, which underpinned African leadership and ownership of the

response to the outbreak. Partnership with health agencies in sub-regional economic blocs ensured further alignment and synergies. (Loembé et al. 2020: 1,000)

A collaborative taskforce was then constituted to lead the implementation of this joint strategy; the early stages of its work involved enhancing national capacity for detecting and containing the virus. Technical know-how and earlier investments in emergency preparedness and response mechanisms during previous epidemic outbreaks like those of Ebola, Lassa fever, polio, and HIV were activated. This infrastructure includes a continent-wide exchange platform that was ‘repurposed for training and information on COVID-19 diagnostics’ as well as a dense network of ‘community health agents that support the response to polio and other diseases ... leveraged for sensitization and to raise the alarm about suspected COVID-19 at the subnational level’ (Loembé et al. 2020: 1001). Furthermore, in collaboration with AU partner countries, the number of testing labs was increased from 2 to 43 between February and mid-March 2020, and training workshops were held to increase surveillance capacity at entry points and to prevent and contain infections.<sup>4</sup>

The AU COVID-19 Response Fund was set up on 26 March 2020 with the aim of ‘strengthen[ing] the continental response to COVID-19 ... and mitigating the pandemic’s socio economic and humanitarian impact on African populations’ (AU n.d.). This fund enabled the Africa CDC to set up the Partnership to Accelerate COVID-19 Testing (the PACT initiative), to mobilize existing public health infrastructure for aggressive testing, tracing, and treatment (AU and Africa CC 2020). In June 2020, following global shortages of medical supplies and the attendant increases in prices, the African Medical Supplies Platform was created as an online marketplace under the supervision of the Africa CDC, the UN Economic Commission for Africa, and the Africa Export-Import Bank, where member countries:

can shop for diagnostics and commodities at fixed, fair prices. For instance, at the start of the pandemic, global demand drove up the price of an N95 mask to \$30 (£24; €26) but this will cost \$2 on the platform. The Africa Export-Import Bank will handle payments and provide loans to member states to purchase equipment, while logistics partners including African national carriers and global freight companies will run delivery. (Wadvalla 2020: 2)

At the subregional level, health ministers from ECOWAS held a meeting to develop a coordinated response to the outbreak two weeks after the World Health Organization (WHO) declared the outbreak a public health emergency of international concern. At the meeting,

the ministers resolved to urgently strengthen critical national capacities for diagnosing and managing cases, including infrastructure issues for quarantine or self-isolation and intensive care unit facilities and implementing robust measures to ensure availability of critical medical supplies, including laboratory materials and personal protective equipment (PPE) in the region. (Ahanhanzo et al. 2021: 2)

These interventions were aided by the existence of institutions like the ECOWAS Regional Centre for Surveillance and Disease Control, which was established as an agency under the West African Health Organization (WAHO) in response to regional epidemics like those of Ebola and Lassa fever. These previous efforts had led to the building of reference laboratories and an increase in the number of epidemiologists in member countries through a field training programme. Surveillance, monitoring, and field investigations were carried out by a regional coordination

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<sup>4</sup> With national outbreaks and consequent border closures, these workshops moved online (Loembe et al. 2020).

platform involving National Public Health Institutes (NPHIs) across member states (Ahanhanzo et al. 2021).

These strong early actions and the efficient regional collaboration in Africa contrasted with the inaction and feet-dragging that characterized the initial response in wealthier countries. In the EU, for example, a study showed that delayed response and failure to deploy existing core capacity worsened the impact of the pandemic:

Our results showed that one of the problems in northern Italy, for example, was that even though there were enough intensive care unit (ICU) beds across the country—and even in the region if they were able to cross a border (into another country)—that capacity was not used. (Gray 2020)

In large part, Africa's strong early response was a tacit recognition of the stark reality that African countries could not afford the scale of infection witnessed by Italy, Spain, and the United States in the first two quarters of 2020. As James Dzansi (2020) observes, 'Whether in terms of the number of doctors, ventilators, personal protecting equipment, or simple test kits, sub-Saharan Africa comes up short'. Given the fragility of national health systems, it was important to concentrate efforts on delaying national outbreaks as much as possible, and to aggressively contain outbreaks once they occurred. Although the absolute number of deaths remained lower than in other world regions, the disease has been more lethal in Africa (Gisselquist and Vaccaro 2021). In a study of 64 hospitals in ten African countries, the African COVID-19 Critical Care Outcomes Study (ACCCOS) found that COVID-19 patients who became critically ill had a higher risk of dying than critically ill patients on other continents. In addition to co-morbidities, lack of essential medical equipment and resources accounted for this higher risk (Biccard et al. 2021).

Moreover, once cases were recorded in individual countries, the national response and attendant health outcomes were shaped by an attempt to balance public health and political considerations. In Ghana, where the sitting president, Nana Addo Danquah Akufo-Addo, was coming up for re-election in December, the political stakes were even higher, as will be seen in the next section.

## **5 The COVID-19 outbreak in Ghana and policy responses**

### **5.1 Pandemic preparedness before the outbreak of COVID-19**

A global pandemic preparedness report published in 2019 revealed a huge gap in Ghana's readiness for a major public health emergency. The Global Health Security Index (GHSI), which provides a 'comprehensive assessment and benchmarking of health security and related capabilities' using the criteria below, ranked Ghana 105th out of 195 countries (Cameron et al. 2019: 5, 8).<sup>5</sup>

1. prevention (prevention of the emergence or release of pathogens);
2. detection and reporting (early detection and reporting for epidemics of potential international concern);
3. rapid response (rapid response to and mitigation of the spread of an epidemic);
4. health system (sufficient and robust health system to treat the sick and protect health workers);

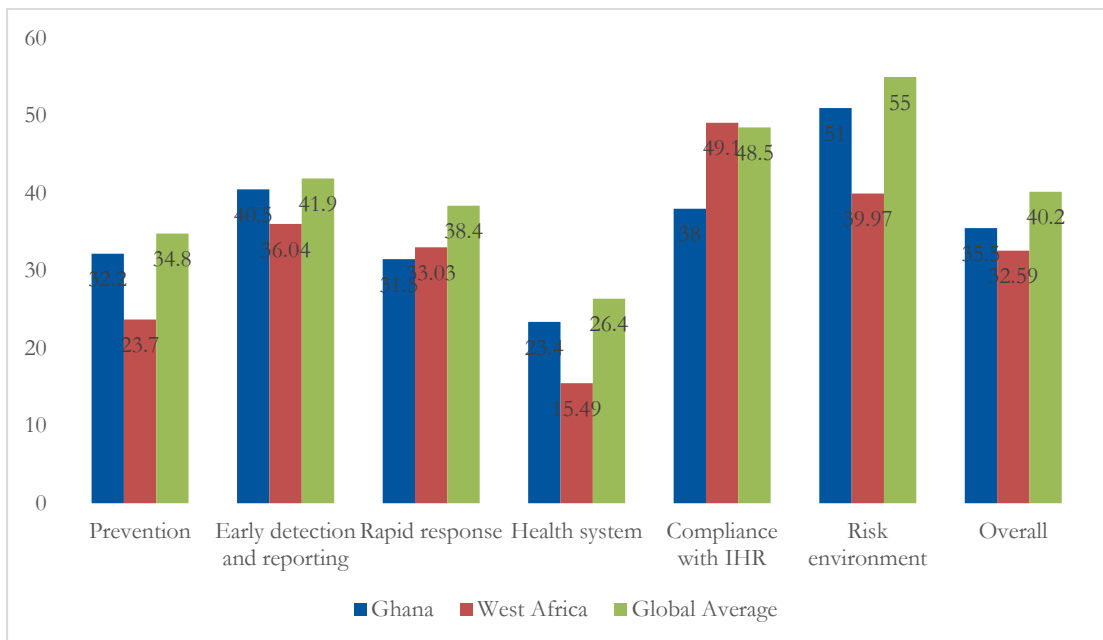
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<sup>5</sup> However, this index ought to be used with caution given that any global index is likely to miss out as much as it captures (Kaiser et al. 2021).

5. compliance with international norms (commitments to improving national capacity, financing plans to address gaps and adhering to global norms);
6. risk environment (overall risk environment and country vulnerability to biological threats).

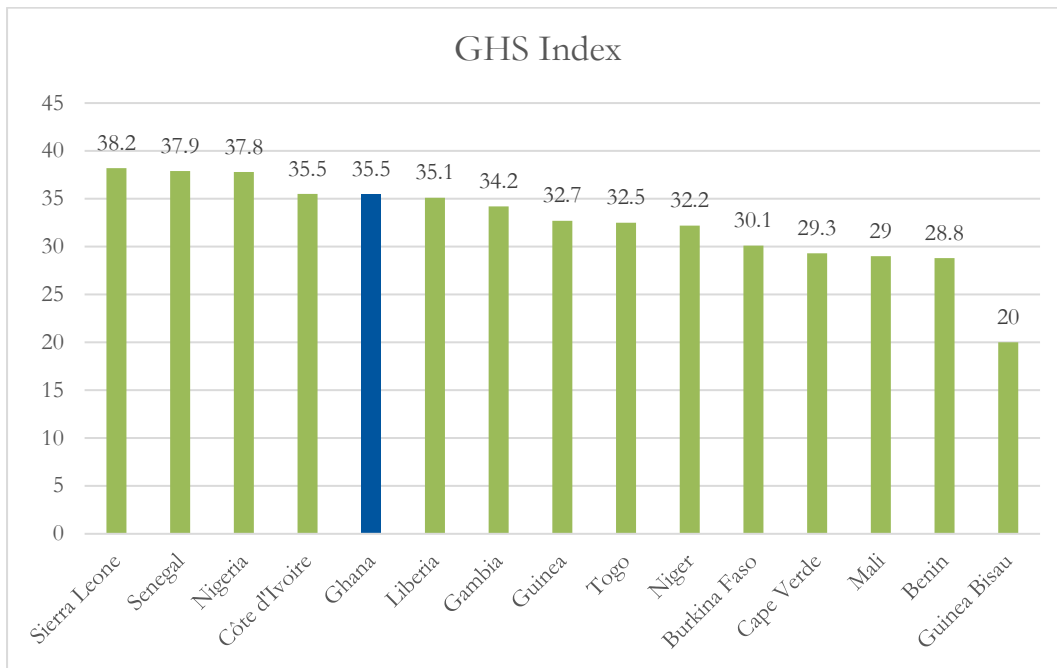
The index is scored on a 100-point scale, with a score below 33.4 considered low while a score above 66.6 is considered high. A country scoring between 33.3 and 66.7 has a medium level of preparedness. The report revealed a worrying lack of preparedness worldwide, with a global average index score of about 40 (see Figure 4). On all but six indicators, the global average score was below 50. West Africa performed worse than the global average on all indicators except ‘compliance with IHR [International Health Regulations]’, where the subregion marginally outperformed the global average by 0.6 points. Ghana performed better than its West African peers on four out of six of the indicators, and on the overall score (35.5 against 32.6), although Sierra Leone, Senegal, and Nigeria performed better than Ghana on the overall score (see Figure 5).

Figure 4: Ghana’s average GHS index score in comparison with West Africa and global average



Source: author's illustration based on GHSI data (Cameron et al. 2019).

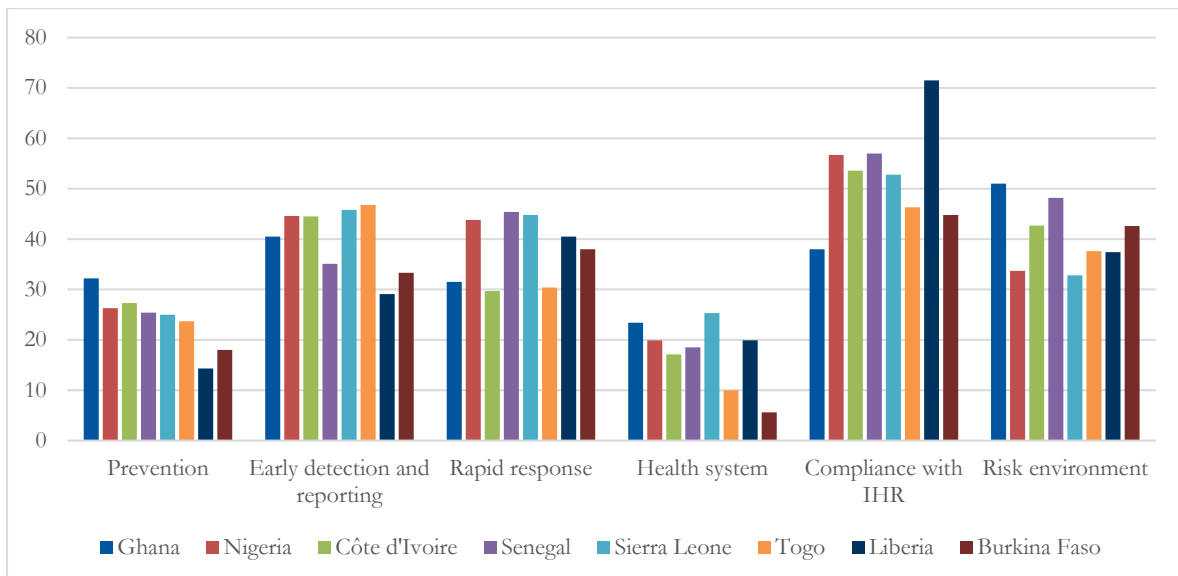
Figure 5: Overall GHSI score for West Africa



Source: author's illustration based on GHSI data (Cameron et al. 2019).

Figure 6 shows common areas of strength and weakness across the West African subregion. For instance, 'health systems' and 'prevention' are generally poor across the selected West African countries in the chart, whereas the general performance looks better across 'compliance to IHR', 'rapid response', 'risk environment', and 'early detection and reporting'. Ghana's best performance was on the 'risk environment' indicator, while its worst was on the 'health systems' indicator.

Figure 6: GHS indicators for selected West African Countries

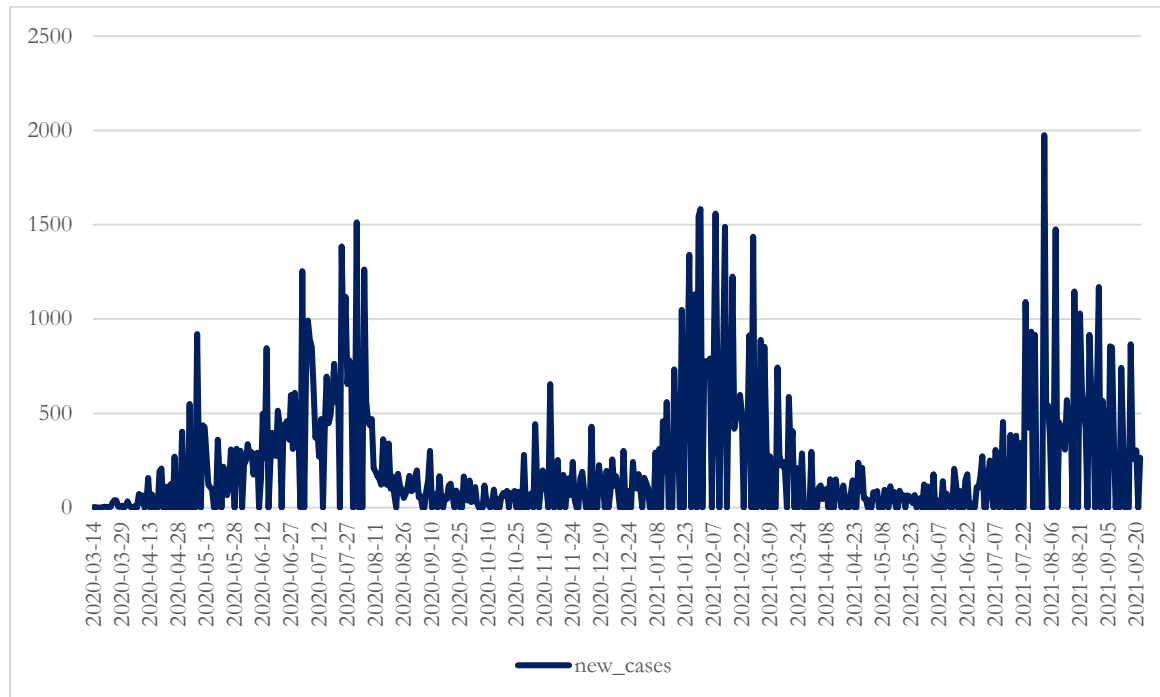


Source: author's illustration based on GHSI data (Cameron et al. 2019).

## 5.2 The trajectory of the COVID-19 outbreak in Ghana

The first two cases of COVID-19 in Ghana were reported on 12 March 2020. As happened in other countries, the number of infections quickly increased, reaching 13,203 confirmed cases and 70 deaths in June 2020. Before the end of December 2020, the country had had more than 54,000 confirmed cases and more than 330 deaths. In September 2021, the country had recorded over 125,000 cases and 1,100 deaths (see Figures 7, 8, and 9).

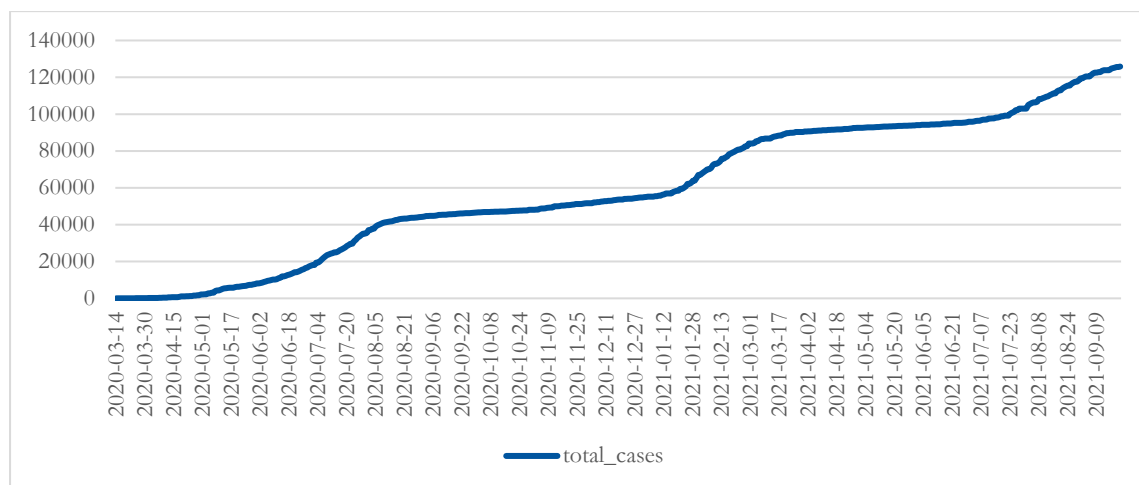
Figure 7: Daily recorded COVID-19 cases in Ghana



Note: figure based on data available at the time of writing, database updated weekly.

Source: author's illustration based on Ritchie et al. (2020), with data from COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (Dong et al. 2020).

Figure 8: Trend in total COVID-19 cases in Ghana

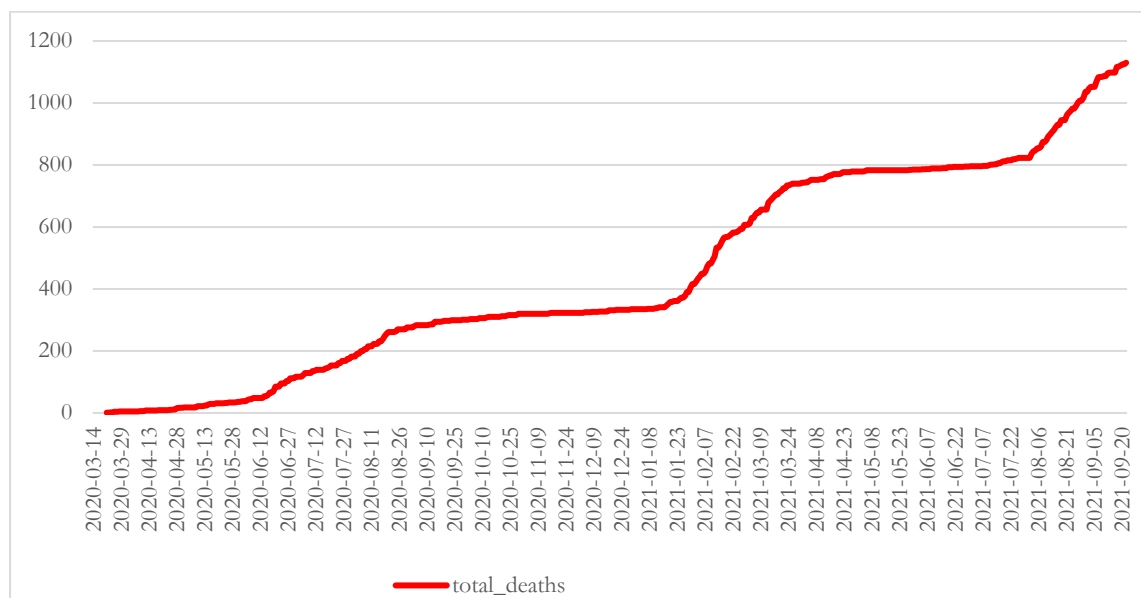


Note: figure based on data available at the time of writing, database updated weekly.

Source: author's illustration based on Ritchie et al. (2020), with data from COVID-19 Data Repository (Dong et al. 2020).



Figure 9: Trend in total COVID-19 deaths in Ghana



Note: figure based on data available at the time of writing, database updated weekly.

Source: author's illustration based on Ritchie et al. (2020), with data from COVID-19 Data Repository (Dong et al. 2020).

By September 2021, Ghana had experienced three separate waves of the outbreak. The first wave occurred in the middle of July 2020, after some of the restrictions on social gatherings were lifted. In the following months, major government programmes requiring large gatherings—including registrations for the new national identification card, the compiling of a new voters' register, and presidential and parliamentary elections in December—were undertaken to much criticism from civil society organizations (CSOs) and professional associations. However, the second wave did not occur until the middle of January 2021, possibly linked to the Christmas and New Year festivities. The third wave was recorded in August 2021 (see Figure 7). The total number of deaths followed the same trajectory as the total number of cases, with rising fatalities as the number of recorded cases increased. By 27 September, total number of deaths had risen to 1,150 (see Figure 9).

### 5.3 Early national response

Ghana's response to the outbreak of COVID-19 drew heavily on its residual capacity. The public health emergency structures were activated in the early months of 2020 before the first cases were recorded. The Emergency Operation Centres (EOCs), the Public Health Emergency Management Committees (PHEMCs), and the National Disease Surveillance Department (NDS) of the Ghana Health Service conducted a readiness assessment and developed a response strategy (Kenu et al. 2020). Additionally, alumni and residents of the Ghana Field Epidemiology and Laboratory Training Programme (Ghana FELTP) and staff of the Ghana Health Service were trained on contact tracing (Kenu et al. 2020).

Shortly after the first two cases were confirmed, the government imposed a number of restrictions including a partial lockdown in Greater Accra, Kasoa, and Greater Kumasi (MoH 2020), and commenced 'enhanced surveillance ... to early detect, isolate and treat all confirmed cases' (Kenu et al. 2020: 72).<sup>6</sup> In addition to these restrictions, the president met with eminent clergymen for

<sup>6</sup> Appendix C summarises the restrictions and mitigation packages contained in the government's policy response.

prayers and consultations, ostensibly to generate goodwill about the measures imposed given the enormous influence of religious leaders in the country (Asante 2020; Prempeh 2021). These activities formed part of the government's six-point strategic objectives (MoH 2020: 18) to:

1. limit importation of cases;
2. slow the spread of infections;
3. provide adequate care for COVID-19 patients;
4. develop and coordinate the response;
5. minimize the socioeconomic impact of the pandemic; and
6. enhance domestic capacity for healthcare and health-related innovations.

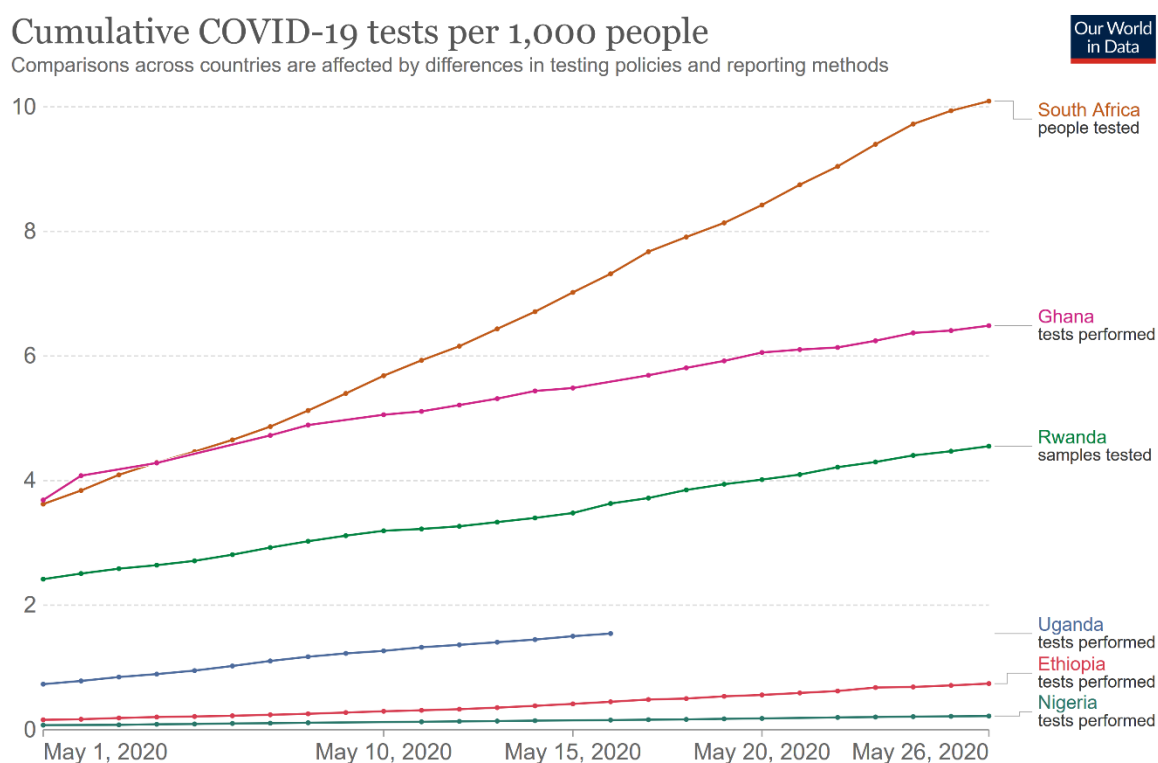
Given the dire socioeconomic fallout from the restrictions, on 5 April 2020 the president tasked the minister of finance to lay before parliament the Coronavirus Alleviation Programme (CAP) (MoFEP 2020). Through the CAP, the Ministry of Gender, Children and Social Protection (MoGCSP), the Ministry of Local Government and Rural Development (MLGRD), and the National Disaster Management Organization (NADMO), together with metropolitan, municipal, and district assemblies (MMDAs) and the faith-based organizations, provided dry food packages and hot meals for over 400,000 members of vulnerable communities in Accra, Tema, Kumasi, and Kasoa. In addition, the government fully absorbed electricity bills for lifeline consumers (0–50 kwt consumption)<sup>7</sup> and water bills from April to June (Owusu and Crentsil 2021; Presidency of Ghana 2020b).

Specific health-related interventions included the procurement of medical supplies needed to fight the pandemic, including coveralls, masks, goggles, non-contact thermometers, and test kits. Further, 2,000 community health workers and volunteers were employed to strengthen the pool of health personnel. This early response strategy prioritized aggressive disease surveillance, contact tracing, and testing (Quakyi et al. 2021). Given resource constraints, scientists at the University of Ghana's Noguchi Memorial Institute for Medical Research (NMIMR) developed an innovative batch-testing system (Owusu and Crentsil 2021). This cost-effective strategy allowed Ghana to significantly scale up testing, and by end of May the country ranked above most other SSA countries, second only to South Africa, the hardest-hit country on the continent (see Figure 10).

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<sup>7</sup> All other consumers got a 50% subsidy.

Figure 10: Total COVID-19 tests per thousands in SSA



Source: reproduced from the COVID-19 Data Explorer, by Our World in Data, under the CC BY 4.0 license. Data from The Our World in Data COVID-19 Testing dataset (Hasell et al. 2020).

In addition, about 100 pick-up vehicles and 2,500 tablets were mobilized for the exercise (Presidency of Ghana 2020a). To boost testing and contact tracing, the initial two testing centres and facilities were expanded to 16, including private providers (Presidency of Ghana 2020c). To remedy the severe disparities in access to quality healthcare that the pandemic laid bare, on 10 May 2020 the president announced a long-term programme to provide each district and region with at least one hospital (Presidency of Ghana 2020c).

While healthcare systems remain weak in Ghana and the Western African subregion as a whole, as can be seen in the GHSI (see Figures 4–6), the ability of quickly mobilize pre-existing capacity in the form of networks of volunteers, previous epidemic control measures, and fortuitously timed logistical acquisitions—such as the deployment of drone delivery and purchase of ambulances—were crucial elements in Ghana’s early pandemic response strategy. However, residual capacity can only provide a short-term reprieve and cannot underscore sustainable public service delivery. Residual capacity is, by definition, episodic and its successful deployment may not be guaranteed under all circumstances. The longer the pandemic lasted, the more difficult it was for residual capacity to hold up and prevent the spread of infection, as will be shown in the next section.

#### 5.4 ‘Fellow Ghanaians!’ The politics of pandemic response

While residual capacity put Ghana in a position to implement a strong early pandemic response, the country’s ability to sustain its initial performance was constrained by the broader political context. COVID-19 threatened to disrupt the calendar of events for the presidential and parliamentary elections in December 2020. With the ban on large public gatherings, political parties could neither hold mass rallies nor engage in grassroots vote canvassing. The ensuing uncertainties generated heated public debate about whether or not to hold the elections as planned (Asiseh 2020; Bomfeh 2020; GhanaWeb 2020). However, given the constitutional complications that would

ensue, there eventually emerged a tacit consensus among CSOs and political parties that the elections should go ahead (Agbele and Saibu 2021).

The main obstacle the Electoral Commission (EC), the country's election management body, faced was how to move forward with its resolve to compile a fresh voters' register. This decision was a controversial one which the largest opposition party, the NDC, had unsuccessfully contested at the Supreme Court. But apart from the political objections to the registration exercise, the EC also had to contend with concerns that it was likely to cause a spike in infections because of overcrowding at registration centres. In response, the EC assured the public that it would enforce all the public health protocols, including social distancing, use of face masks, provision of handwashing stations, use of temperature guns, and the introduction of a digital queuing system. However, a report by the Coalition of Domestic Election Observers (CODEO) indicated that some registration centres did not follow the protocols (Agbele and Saibu 2021).

While all the political parties were negatively affected by the pandemic restrictions, the incumbent president, Nana Addo Danquah Akufo-Addo, of the NPP, enjoyed the advantage of incumbency. He regularly appeared on national television to provide updates on the state of the outbreak. The president infused each appearance with an air of showmanship, especially when he was announcing the introduction of mitigation packages such as subsidies on utilities. The speeches were intoned with a performative flair to convey sombre competence. In each appearance, the president was clothed in wax print shirts that symbolically conveyed the core theme of the speech delivered that night. With a deadly disease raging and social life brought to a standstill, these broadcasts came to capture the public's attention with their well-rehearsed performance and spectacle. The president soon earned the nickname 'Fellow Ghanaians!', the signature greeting with which he opened each address. Later in the year, the Ghana Textiles Printing Company (GTP) outdoored a new design called 'Fellow Ghanaians' as one of the commemorative designs for the year (Aikins 2020). From March to December 2020, the president delivered 20 speeches, 19 of them before the general elections on 7 December 2020 (Presidency of Ghana 2022).

The incentive to exploit crisis for political advantage has been widely acknowledged in crisis scholarship (Boin and Hart 2003; Klein 2007). The nature of the pandemic and its containment measures provided an opportunity for the president to demonstrate competence and compassion while hobbling the opposition party's ability to mobilize for votes ahead of a crucial election. The reality of the situation in Ghana and elsewhere was not lost on analysts, some of whom characterized the social support packages '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' (Tsikata and Torvikey 2021: 3–4).

However, as the elections drew closer, the government started to ease the containment measures. In May 2020, hotels, bars, and restaurants were allowed to open under enhanced social-distancing procedures (Graphic Online 2020a). In June, restrictions were further relaxed. Religious services with congregations not exceeding 100 were allowed, as were other social gatherings like private burials and weddings, provided they also did not exceed 100 attendees (Graphic Online 2020c). With progressive relaxation of restrictions, compliance with the overall safety protocols, such as mask wearing, grew increasingly lax.

As the election approached, the rising number of COVID-19 cases was no longer the foremost subject of public discourse (Nikoi 2021). The ensuing situation, according to Agbele and Saibu (2021: 9), amounted to 'throwing caution to the wind'. To compound the situation, with a large backlog of untested samples going back weeks, the director general of the health service, Dr Patrick Kuma-Aboagye, announced that the service was thenceforth going to prioritize the testing of

symptomatic cases (Graphic Online 2020b). This announcement effectively marked the end of the country's robust initial efforts: 'Contact tracing consequently scaled down to a near dormancy in parts of Ghana' (Quakyi et al. 2021: 1).

Voting day in Ghana has always generated anxieties over fears of possible outbreaks of violence (Lynch et al. 2019). In 2020, these fears were overtaken by concerns that the election day itself could lead to a spike in COVID-19 infections. However, the voting turned out to be smooth and efficient (Selormey and Asiamah 2021). In sharp contrast with the long queues and tensions that voters in previous elections had had to endure, it took '3–5 minutes for the average voter to be verified and to vote', an achievement which the electoral commissioner proudly described as 'a pleasant and seamless experience' (Mensa 2020).

Thus, electoral-related activities affected the trajectory of COVID-19 infections in Ghana, but the election itself probably did not significantly contribute to the rate of infection. Overall, the safeguards put in place by the EC on voting day were adhered to (Nugent et al. 2021) and the data suggest that the voters' registration exercise and vote canvassing in the months leading to the elections contributed more to the rise in cases than the election itself. As noted by Agbele and Saibu (2021: 12), 'The registration period ... recorded 21,724 new infections, representing 34.1 per cent, while the remaining 14 weeks until 7 December saw only 16.8 per cent increases in infections'.

## **6 Conclusion: residual capacity and the politics of pandemic response**

Institutional and political factors mediated the trajectory of the COVID-19 outbreak in Ghana in the first year of the outbreak. Institutionally, the country benefited from decisive early action at the continental and subregional levels, which laid a foundation for the national response. Further, like other West African countries, Ghana already had a public health emergency response infrastructure in place from the 2014 Ebola outbreak, which was quickly reactivated and repurposed for the COVID-19 response. This included an extensive network of community health agents who were deployed for contact tracing and community sensitization.

While Ghana's overall capacity remains weak, this public health response infrastructure and continental coordination helped the country to gain control in the first months of the outbreak. When the country began recording cases, the government acted swiftly and decisively. These early actions did not generate a public backlash; on the contrary, a survey found that 'as many as 87 per cent of respondents considered that the country has done well or very well in fighting COVID-19' (Nugent et al. 2021: 3). However, with an impending election later that year and fearing political backlash, the government began easing restrictions even while the case count was still rising.

Ghana's case shows the need to rethink the way we conceptualize state capacity. It is necessary to distinguish between 'residual' capacity that may emerge only episodically and in response to unusual conditions and 'core' capacity that characterizes state performance in relatively settled times. Regional organizations like the AU and ECOWAS helped member countries to tap into a common pool of expertise and resources, allowing capacities embedded in individual countries to be 'abstracted' and 'distributed' across the region. Given the policy confusion, feet-dragging, and deeply statist responses that marked the early stages of the pandemic in wealthier countries with much higher levels of state capacity, this successful coordination by the AU and ECOWAS is noteworthy. Additionally, sheer luck, such as Ghana's fortuitous procurement of ambulances and the deployment of drone delivery of medical supplies, allowed the country to leapfrog over entrenched infrastructural bottlenecks. However, sustainable public service delivery over the long term cannot rely on residual capacity, which, because it is episodic, cannot be the foundation of a

long-term strategy. Moreover, the circumstances under which residual capacity can be activated remain uncertain. The fundamental social and political disruptions caused by the pandemic opened the door for measures which would otherwise have been impossible. Future research could explore the possibility of deploying residual capacity in relatively more settled times.

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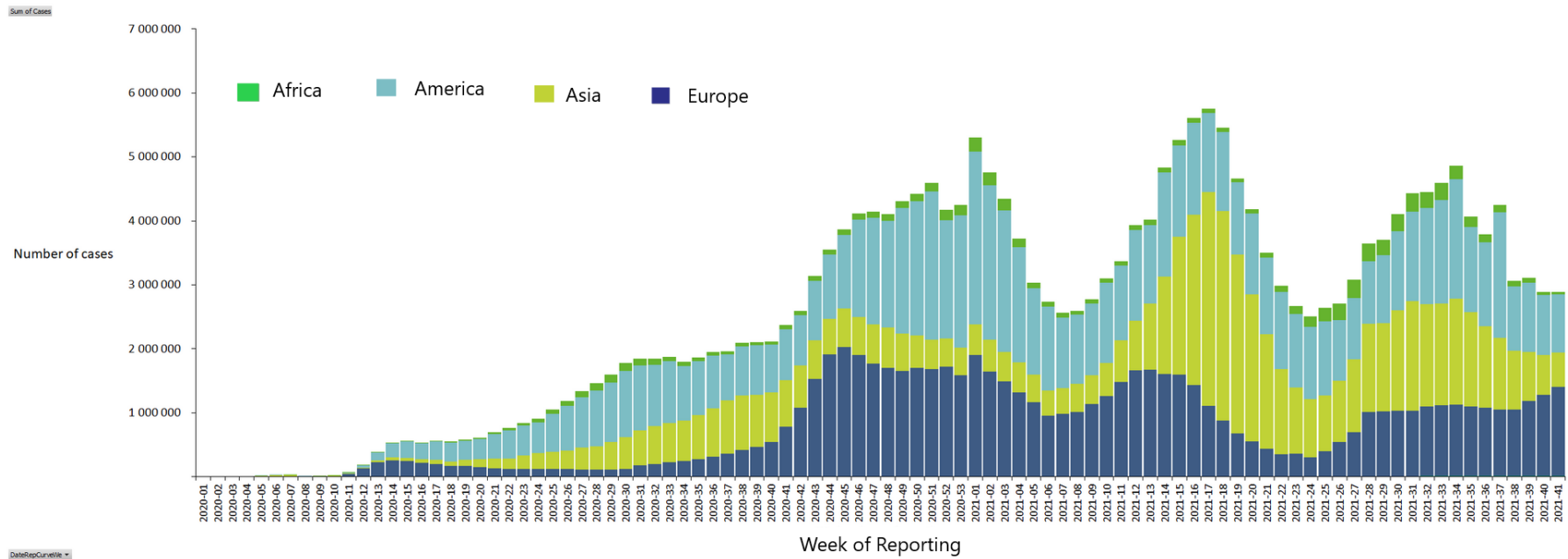
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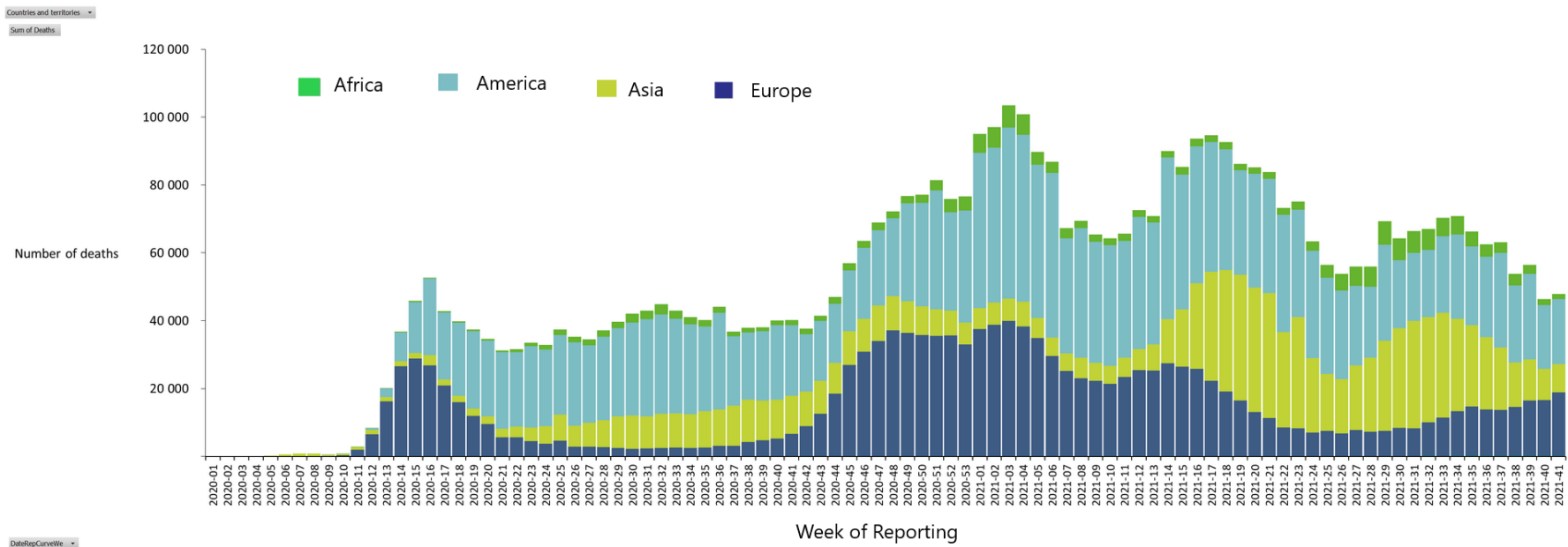
## Appendix A: COVID-19 cases and deaths worldwide

Figure A1: COVID-19 cases worldwide



Source: reproduced from European Centre for Disease Prevention and Control (multiple dates), under the CC BY 4.0 license.

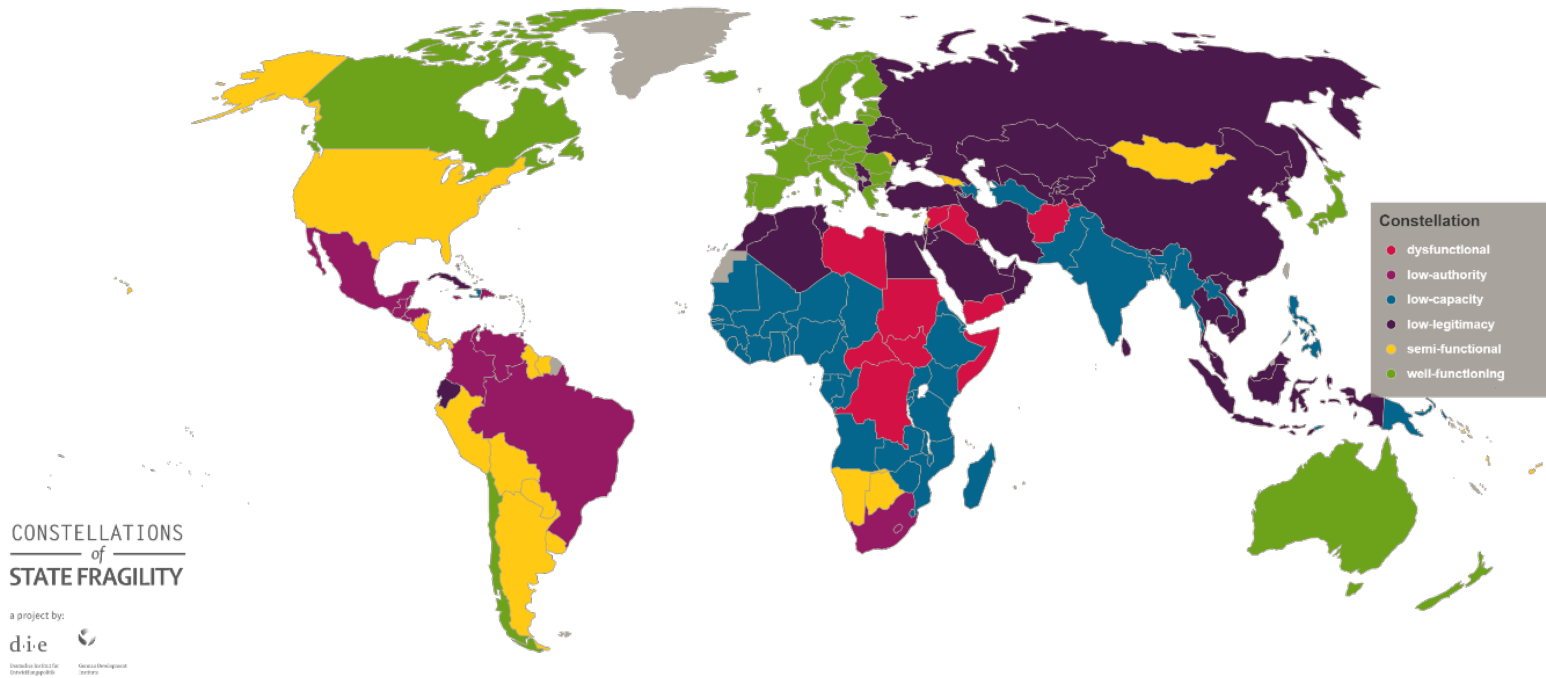
Figure A2: COVID-19 deaths worldwide



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## Appendix B: State capacity across world regions

Figure B1: State capacity



Source: reproduced from Grävingholt et. al. (2018), under the CC BY 4.0 license.

## Appendix C: Policy response to the COVID-19 pandemic in Ghana

Table C1: Policy response to the pandemic, Ghana

<b>Restrictions</b>		<b>Relief efforts</b>	
<b>Interventions</b>	<b>Duration</b>	<b>Mitigation packages</b>	<b>Duration</b>
<i>Ban on public gatherings</i>		Insurance package for frontline health workers and exemption of all health workers from paying income taxes	5 April – December 2020
Conferences and workshops	16 March – 1 June 2020	Frontline health workers, as defined by the Ministry of Health, will continue to receive the additional allowance of 50% of their basic salary per month	5 April – December 2020
Religious activities banned from 16 March 2020, easing it to 100 members and per hour on 1 June 2020 and removal of the quota restrictions on 1 August but for 2 hours	16 March – 1 August 2020	100% water and electricity bills absorbed for lifeline consumers	5 April 2020 – March 2021
		50% water and electricity bills absorbed for the rest of Ghanaians	5 April – December 2020
Sports activities: training started 1 August 2020 but premiere leagues started on 30 October 2020	16 March – 30 October 2020	About 2% reduction of interest rates by banks, effective 1 April 2020	April to December 2020
Tourism sites and attractions	16 March – 1 August, 2020		
Issuance of emergency legislation, in accordance with Article 21 (4) (c) and (d) of the Constitution of the Republic, to embody these measures, and the Minister for Health to exercise his powers, under Section 169 of the Public Health Act, 2012 (Act 851)	16 March 2020		
<i>Closure of national borders</i>			
Air borders closed to human traffic	23 March – 31 August, 2020		
Borders by land and sea closed	23 March 2020 to date		
<i>School closures</i>			

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Final year students of JHS, SHS, and university	15 March 2020 to 15 June to 2020
All other students	16 March 2020 – 15 January 2021
<i>Lockdown restrictions</i>	
Partial lockdown of Greater Accra and Greater Kumasi metropolitan areas	30 March – 19 April 2020
Imposition of Restrictions Act, 2020 (Act 1012) authorized the restrictions on movement of persons in the Greater Accra Metropolitan Area (GAMA, which includes Awutu Senya East), and the Greater Kumasi Metropolitan Area and contiguous districts	
Transportation and seating restrictions (half capacity)	27 March – 1 August 2020
<i>Mask and social-distancing mandate</i>	
Mandatory/recommended nose mask wearing	19 April to 27 March 2022
Social-distancing and hygiene practices and protocols including stop shaking hands, hand washing	21 March to 27 March 2022

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Source: author's construction based on multiple presidential speeches (Presidency of Ghana 2022).