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Humanity over economy: Biopolitical responses to the COVID-19 pandemic in Ghana

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WIDER Working Paper 2022/146

Humanity over economy: biopolitical responses to the COVID-19 pandemic in Ghana

James McKeown*

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Abstract: This study posits that pandemics should be regarded as complex, open-ended phenomena that cannot be reduced to biology and epidemiology. The research assesses Ghana's effectiveness in governing the COVID-19 pandemic contrary to apocalyptic predictions. This paper critiques Ghana's responses to the COVID-19 pandemic through the lens of Foucault's *biopolitics*. The main result of this study showed that Ghana survived the pandemic because of effective policies, not providence. The study also found that the 'Ghana Beyond Aid' self-reliance agenda was given further impetus. The study concludes that the moderately intrusive biopolitical responses to COVID-19 did not deteriorate democratic norms in Ghana.

Key words: COVID-19, humanity, biopolitics, government effectiveness, biosurveillance, paradoxes, Ghana

JEL classification: I15, H12, J88

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1 Introduction

The onslaught of the Coronavirus disease (COVID-19) pandemic brought in its wake apocalyptic prophecies of dead bodies on the streets of Africa. African healthcare systems and the economy were expected to suffer the most extreme shocks, making the fight against COVID-19 almost a Sisyphean task. Dispelling the seeming panic and paranoia that welcomed COVID-19 in the initial stages, the President of Ghana, while giving hope to the populace, received international applauses for offering some much-needed perspective on the general economic crisis (Peat 2020) and the vicissitudes of the pandemic with the statement: ‘We know how to bring the economy back to life. What we do not know is how to bring people back to life’ (Akufo-Addo 2020; Peat 2020).

This study investigates the health pandemic through the lenses of COVID-19 as a complex phenomenon in current world politics, involving aspects of COVID-19 responses that cannot be reduced to mere epidemiological or biological approaches. The research hypothesizes how Africa, particularly Ghana, has managed the pandemic contrary to the apocalyptic predictions. This paper will critique certain aspects of the COVID-19 pandemic responses relating to techniques associated with Foucault’s notion of biopolitics. Since the time of Michel Foucault, biopolitics has been employed and expanded in social theory to study the methods and procedures by which human life processes are governed by states (Anthrobiopolitics 2013; Foucault 2003). The study also assesses the extent of intrusiveness of the biopolitical responses while assessing whether Ghanaians have not suffered the predicted vagaries of COVID-19 because of effective state capacity or mere luck. In doing so, this paper approaches the COVID-19 pandemic and related issues from a more critical theoretical perspective, something missing in many studies of the pandemic in Africa. This paper contributes to an emerging body of work that looks beyond aggregate outcomes to investigate the correlation between state policy implementations and pandemic outcomes of COVID-19 in Ghana. In addition to citing examples from Africa and other contexts, this study is most strongly informed by the Ghana context.

In December 2019, an unknown cluster of pneumonia cases in Wuhan, China, triggered concern among health officials. A seafood market in Wuhan was immediately suspected to be the epicentre of the unknown disease. An increasing number of human infections and subsequent evidence of human-to-human transmission made COVID-19 (SARS-CoV-2) more contagious than any known strain of Coronavirus, including the Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) and the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) (Chan et al. 2020; Tan et al. 2020; Wang et al. 2020). At a meeting of the International Health Regulations Emergency Committee, the director-general of the World Health Organization (WHO) declared COVID-19 a ‘public health emergency of international concern’ on 30 January 2020 (WHO 2020a). The WHO eventually declared the outbreak of COVID-19 a pandemic on 11 March 2020 (WHO 2020b).

It was impossible not to notice the arrival of the new virus in early 2020. Global attention began to focus on China and the potentially highly lethal new Coronavirus, which had jumped barriers and transmitted worldwide. One of the initial reactions was the search for people to blame as the ones spreading the virus. This situation aggravated prejudice, conspiracy theories, xenophobia, racism, and ethnic profiling towards people from China (Burton 2020). Italy, the first country in Europe to suffer severely from the pandemic, equally suffered from varied forms of suspicions (Nadeau 2020). Prejudices against Muslims in India also exacerbated after Indian authorities suspected the gathering and preaching of a form of Sunni Islam by the Tablighi Jamaat Islamic group as people spreading the virus (Kolachalam 2020). Police in Paris discriminated against ethnic minorities during quarantine (Dodman 2020). The LGBTQ community did not escape blame in

South Korea as the source of the virus (Thoreson 2020), while xenophobic attacks targeted at non-citizens, especially people of colour, escalated in China during the period (Asiedu 2020). Contrary to the warm reception mostly enjoyed by Ghanaians who reside in Europe and North America whenever they visit Ghana, Ghanaian citizens returning from the West suffered from suspicion as the source of the virus.

The media extensively reported the new virus, and it was also discussed by governments and public health experts, fuelling public anxiety and angst for survival. By the first quarter of 2020, many countries had already put in place unusual lockdowns and measures of isolation, which affected millions of people worldwide to limit, if not stop, the explosive spread of the Coronavirus. Several countries cut air links and closed businesses, schools, stadia, and many public places. Toiletries vanished from the shelves of stores. Similar to the H1N1 influenza pandemic, the new virus was a ‘monster at our door’ (Davis 2005); perhaps, it was a ‘chicken-little’ fable, exaggerated by public health officials (Briggs and Nichter 2009) and the media.

The scale of the COVID-19 restrictions brought questions about their legitimacy and proportionality relative to the effects of the virus. The restrictions indicated that some policy-makers had placed health over and above the economy. However, the virus’s rapid spread could arguably be linked to the initial reluctance of many governments to take strong measures at an earlier stage because of fear of startling their economies. The daunting challenge of choosing between life and the economy led the President of Ghana, Nana Addo Dankwa Akufo-Addo, to make the famous statement about not knowing how to bring people back to life but knowing how to resuscitate an ailing economy. In many countries, policy-makers and health professionals, particularly in advanced economies, failed to prepare for the impact of COVID-19. This led to reactive yet aggressive measures such as undertaking contact tracing, compulsory testing of patients and travellers, and readying health facilities to admit COVID-19 patients or patients showing signs of the novel disease. Health systems became utterly overwhelmed, particularly in Europe and the United States, because of inadequate clinical preparations and response to COVID-19. Protective gears were in short supply; intensive care unit (ICU) beds were fully booked to the extent that care had to be triaged to those with the best chance of survival (Kassam 2020; Winfield 2020). As compared by Lisa Forman in *The Evolution of the Right to Health in the Shadow of COVID-19* (2020), there was a quintessential Darwinian sense of natural selection where either patients adjust to changing conditions or perish. The most vulnerable, especially the elderly, had to be triaged to save the crumpling health system and the economy. Despite enormous efforts to understand COVID-19, our understanding of the virus’s dynamics remains limited. As has been argued by Allan Brandt (2013) on HIV/AIDS, it is probably too early to write the history of the COVID-19 pandemic.

In many aspects, the pandemic has created a deep socio-economic crisis and health vulnerabilities resulting from decades of neoliberal supremacy. Neoliberalism has dominated national and global policy decision making in the form of austerities and has manifested in a reduction in healthcare spending. Like other social sectors, healthcare has been commoditized, privatized, and *profitized* (McGregor 2001; Williams and Maruthappu 2013).

The COVID-19 pandemic tore countries between focusing on strengthening their health systems, saving the economy, or implementing selective pro-poor interventions (Frenk et al. 2014). Other governments worldwide saw COVID-19 as an opportunity and, under the guise of responding to the pandemic, hurried to increase their emergency powers and imposed limitations on human rights (Forman 2020; Funk and Linzer 2020; Swan 2020; Tidy 2020).

With infection rates that have already affected income gradients in some places, COVID-19 has exposed the fault lines and inadequacies of the global social and economic system. The ravaging

COVID-19 pandemic has further highlighted the shortcomings of global health systems, weak social safety nets, and unstable employment (Forman 2020). These failures exposed deep vulnerabilities in advanced economies' global healthcare systems, raising concerns about the impacts of the pandemic on health systems in low- and middle-income countries (Coppola et al. 2020; Forman 2020). African healthcare systems and the economy were expected to suffer the most extreme shocks (Lone and Ahmad 2020). Any attempt by Africans to fight against the Coronavirus disease was considered a Sisyphean task at the initial stage. There were apocalyptic prophecies and imaginations of corpse-dotted streets in Africa (Okereke and Nielsen 2020). On the contrary, Africa appears to have escaped the prophesied health dangers of the COVID-19 pandemic, thereby creating a puzzling oxymoron for health researchers. Although the focus of this study is Ghana, it is sufficiently proper to observe through the pinhole to understand the paradox of the pandemic relating to the gloomy predictions on Africa.

The remainder of the study is structured as follows: the next section discusses the African paradox of the COVID-19 pandemic. Section 3 theorizes the pandemic responses, while Section 4 discusses state capacity and effectiveness in Ghana. Section 5 presents in detail the immanence of biopolitics of pandemics, while Section 6 examines the democratization crisis under COVID-19. Section 7 concludes.

2 The African paradox of the COVID-19 pandemic

The Coronavirus has affected millions of individuals worldwide (Viglione 2020), changed life as we know it, and irreversibly altered the way we live, with a global return to normalcy almost impossible (Žižek 2020b). At the outset of the pandemic, there was considerable debate on how it might touch Africa, and there were fears of disastrous repercussions for the continent's health systems (Nepomnyashchiy et al. 2020; Paintsil 2020). As the pandemic progressed, it became clear that it would protract considerably more than initially anticipated. Critical issues concerning the nature of the disease and its short- and long-term effects on health and wellbeing became topical. The billionaire philanthropist Bill Gates warned as early as February 2020 'that the Coronavirus could hit Africa worse than China' (Wasserman and Moynihan 2020).

Contrary to dire predictions of cataclysmic proportions, COVID-19 appears to have mainly avoided Africa (Bamgboye et al. 2021; Lawal 2021; Rwema et al. 2020). Africa has reported the lowest number of cases and deaths compared to other regions. By 4 May 2022, the African Centres for Disease Control and Prevention (Africa CDC) database and Worldometer estimated that the continent's burden of the disease was 11,458,664, which translated into about 2.3 per cent and 4.06 per cent of global cases and deaths, respectively (Africa CDC 2022).

The first case of the Coronavirus in Africa was reported on 14 February 2020 when a Chinese national tested positive after arriving in Cairo, Egypt. Many African countries were on high alert, with airport personnel in masks checking temperatures and compiling data of new arrivals for contact tracing at a time when Europe had barely woken up to the threat of the Coronavirus (Pilling 2020), a situation that typified the irony of the story of a race between the tortoise and the hare.

African health experts were worried about chronic shortages of supplies like masks, oxygen, and, even more fundamentally, soap and water that is needed to slow the spread of the disease. According to the United Nations, only 15 per cent of sub-Saharan Africans had access to basic hand-washing facilities in 2015 (UNICEF 2018). Egger et al. (2020) found that just 6.8 per cent of households in 30 countries in sub-Saharan Africa could afford to stay at home without jeopardizing

their welfare and health. In a continent where a simple-to-treat disease like malaria kills hundreds of thousands a year and where many people go to the hospital to die, it was not surprising that many Africans feared the COVID-19 outbreak could prove catastrophic considering their struggling health systems. The only consolation was that Africa was not new to infectious diseases, so it was a case of ‘here comes another one’. However, from what was happening in Europe, Africa had no chance if COVID-19 was to spread on such a large scale.

2.1 Baseless predictions?

At the onset of the crisis, it was feared that Africa’s underdeveloped and under-resourced health systems would pose a significant obstacle to the continent’s pandemic response. Given the fragility of the continent’s health systems, it was reasonable to be pessimistic about Africa’s ability to endure the pandemic (Martinez-Alvarez et al. 2020; Paintsil 2020). There were only 2,000 ventilators across 41 African countries, 5,000 ICU beds across 43 countries, and a doctor-to-patient ratio of 0.2 per 1,000 in sub-Saharan Africa. The African Center for Disease Control described this dearth of intensive care beds and ventilators as ‘catastrophic’ (Wadvalla 2020). In March 2020, the WHO estimated that African countries had an average of nine ICU beds per one million people (Ayebale et al. 2020). Many of Africa’s limited ICU beds did not have ventilators. Mauritius, with a population of 1.2 million, had 121, while oil-rich Chad, with a population of 15 million, had only 10 beds in the ICU (Reuters 2020). The combined ICU beds of Nigeria, Ethiopia, and Egypt, with a population of 400 million, could boast a pitiful total of 1,920 critical care beds. Uganda could only operate 70 out of its 268 ICUs because of a shortage of trained staff to operate the units or malfunctioning equipment. Kenya had non-COVID-19 patients already occupying 94 per cent of its 518 ICU beds in public and private facilities (Hourel et al. 2020). South Sudan, a country that had five vice presidents and a population of 11 million, could boast of no more than four ventilators in the entire country. The Central African Republic had three ventilators for its five million people, whereas Liberia had only six working ventilators. While Somalia had no ventilators, Ghana, a country of over 30 million people, had 200 ventilators (Maclean and Marks 2020).

With dense population and poverty in informal settlements, African cities were predicted to pose difficulties for effective policies, such as lockdowns and social distancing. Apart from crowded housing, most people who work in urban areas do so in the informal gig economy (Dingel and Neiman 2020), forcing them to choose between providing for their families and risking infection. COVID-19 spreads rapidly in densely populated and crowded locations. Therefore, it is puzzling why Accra, Lagos, Kinshasa, Cairo, and Addis Ababa have lower COVID-19 infection rates than London, Sao Paulo, Mumbai, New York City, Istanbul, and Levallois-Perret (Abdool Karim 2020; National Institutes for Communicable Diseases (NICD) 2020; Nordling 2020). According to Troeger (2022), COVID-19 was not a leading cause of death in Africa, even at the peak of the pandemic. Some researchers have proposed alternative explanations for the so-called African paradox of COVID-19 infections (El-Sadr and Justman 2020; Mbow et al. 2020; Nordling 2020; Ntoumi and Velavan 2021).

2.2 The paradoxes

Several hypotheses have been advanced to explain why Africa has largely escaped COVID-19-related deaths, including the argument that other coronaviruses and the possible presence of SARS-CoV-2 antibodies found in some Africans have induced cross-reactive herd immunity (Shrock et al. 2020) and that pre-exposure to related viruses may have decreased the vulnerability of people to COVID-19.

Although the *effectiveness* of the African state (Gisselquist and Vaccaro 2021) is less developed than in other parts of the world, the *residual capacity* (K. T. Asante 2022) of many African countries cannot be ignored in the spectrum of justifications for Africa's success story. African countries that fought the world's deadliest Ebola epidemic from 2013 to 2016 had already perfected public health protocols such as isolation, contact tracing, and quarantine that were implemented in response to the COVID-19 pandemic (Soy 2020). Community health professions were quickly repurposed to attend to issues relating to COVID-19 (Soy 2020). As Ditekemena (2020) and AFIDEP (2021) further argue, Africa's history with other pandemics like HIV/AIDS and Ebola may have equipped the continent more than initially thought to deal with COVID-19.

More so, a study conducted by researchers at the University of Maryland in the United States portends a correlation between temperature, humidity, and latitude and the spread of COVID-19 (Sajadi et al. 2020). According to the study, the COVID-19 virus spreads more rapidly when the temperature and humidity drop. The pandemic's worst-hit African nations were the ones outside of the tropics. The spread of the virus surged in South Africa during winter in the southern hemisphere. Cold and dry conditions were potentiating factors in the spread of the virus. However, these factors alone cannot fully explain the variances in the disease transmission (Mecenas et al. 2020; Sylvia 2020).

The African Institute for Development Policy (AFIDEP) expressed initial concerns that the increased incidence of deadly infectious diseases, such as HIV/AIDS and tuberculosis, had the propensity to put Africans at a greater likelihood of high death rates due to the spread of COVID-19 (AFIDEP 2021). However, underlying severe health conditions such as heart disease, diabetes, and obesity, which are not highly prevalent among Africans, have emerged as riskier factors, leading to higher mortality rates for those infected by COVID-19. This situation may have led other researchers to argue that exposure to polio, measles, and tuberculosis vaccines may have resulted in good immune responses (D. Ghosh et al. 2020).

Nepomuceno et al. (2020) hypothesize that Africa's youthful population age structure has acted as a buffer against the acute morbidity and death impact of the COVID-19 pandemic. With severe illness and death rates from COVID-19 being experienced much more severely at older ages, having a young population is generally protective for African countries. Globally, many of the people who died were over age 80, and Africa is home to the world's youngest population. According to the United Nations Population Division, as cited in a report by the South African Department for Social Development and Statistics South Africa, only 1.7 per cent of sub-Saharan Africa's total population is 70 years or older, compared to 12.7 per cent in Europe and North America. Approximately 75 per cent of the African population is less than 35 years of age, and African countries may have benefited from a predominantly young population (Frost et al. 2021; United Nations 2019).

Although Africa's youthful population structure is widely regarded as a factor in the region's low COVID-19 transmission and death rates, there is a substantially increased risk of severe COVID-19 infection among young persons in low-income countries with limited health infrastructure (AFIDEP 2021; Nepomuceno et al. 2020). The WHO, while analysing the social and environmental factors seen behind Africa's low COVID-19 cases, stated that 'The pandemic has largely been in younger age groups. About 91% of COVID-19 infections in sub-Saharan Africa are among people below 60 years, and over 80% are asymptomatic' (WHO Africa 2020). In a study of 64 hospitals in 10 African countries, the African COVID-19 Critical Care Outcomes Study (ACCCOS) discovered that in Africa, COVID-19 patients had a greater risk of mortality than critically ill patients on other continents (ACCCOS Investigators 2021). Gisselquist and Vaccaro (2021) conclude that although the absolute number of deaths remained lower than in other regions, the disease has been more lethal in Africa.

Meanwhile, others postulate a more mundane explanation of luck and insufficient data in Africa on the rate of infection and casualties (Ogimi et al. 2021; Özdemir 2020; Thompson et al. 2021). Indubitably, low testing rates undermined the African response to COVID-19. Nonetheless, the region's testing numbers have proven valuable for policy, as they reflected the infection trends within a country, and many undiagnosed COVID-19 infections were asymptomatic (WHO Africa 2022). More so, there is no indication that many COVID-19 deaths have been missed, or there have been miscalculated death figures or an unaccounted clutter of corpses on the streets of Africa (WHO Africa 2020). It is a wonder how Africa could have hidden the magnitude of predicted deaths from the rest of the world. As Wu et al. (2020) admit, low testing and poor 'testing sensitivity' undermined the official records of confirmed cases. Notwithstanding, the official records of confirmed deaths provided a more reliable metric because it was difficult for many deaths to go unreported compared to cases of infection. The banal explanations for the African paradox are, at best, speculative and fail to recognize the early African responses to COVID-19 that have made lives live, even to the detriment of the economy.

In contrast to the strong early response and effective regional collaboration in Africa, the initial response in wealthier nations was marked by inertia and reluctance. There were fears that the new virus may swiftly overwhelm the continent's primarily fragile and vulnerable health systems. Africa's robust early response was a tacit acknowledgement of the ominous reality that African nations could not afford the level of infection seen in Europe, the United States, and other regions. Many African governments acted promptly to prevent the spread of the virus by enforcing stringent lockdowns highly supported by the public. Some countries, such as Lesotho, acted swiftly even before the first case of infection was recorded (Khan 2022). The African CDC mobilized existing public health infrastructure for aggressive testing, tracing, and treatment. In June 2020, the African Medical Supplies Platform was established as an online marketplace under the supervision of the Africa CDC, the UN, the Economic Commission for Africa, and the Africa Exim Bank, where African countries can shop for diagnostics and commodities at fixed, fair prices. African Medical Supplies Platform sold N95 masks for US\$2 at a time when global demand had driven up the price of an N95 mask to US\$30. The Africa Export-Import Bank processed payments and offered loans to member governments for the acquisition of equipment while logistics partners, including African national carriers and global freight companies, ran delivery (Wadvalla 2020).

Never has almost the entire African continent been so responsive to infections, making it difficult to highlight the success story of a particular country. However, this paper focuses on Ghana as it represents a unique case study for examining the responses to the COVID-19 pandemic in Africa. First, Ghana was widely admired and hailed as Africa's 'poster child' in the fight against the pandemic. Second, Ghana resembles the gold standard and is a useful example of the positive results of African responses to COVID-19. Third, Ghana's lauded accomplishment is typically portrayed as a sign of renewed optimism in the resilience of African health systems and success in the context of COVID-19 protocols' broader applicability throughout Africa.

The Director of WHO, Tedros Adhanom Ghebreyesus, in his opening remarks at the media briefing on COVID-19 on 1 March 2021, noted, 'Today, Ghana and Côte d'Ivoire started vaccinating health workers against COVID-19, becoming the first countries to begin vaccination campaigns with doses supplied through COVAX' (WHO 2021). After which, he further tweeted, 'I salute the example set by President @NAkufoAddo in receiving the first #COVID-19 vaccination through the #COVAX Facility. Your leadership is key to promoting confidence in this life-saving tool in & across Africa' (Modernghana 2021). Fourth, Ghana's situation may not necessarily reflect the entire African continent, but it offers a quintessentially archetypal inquiry and analytical tools that may represent the approaches adopted (Amo-Agyemang 2017) in hosting the unwelcomed guest, COVID-19, in other African settings. Finally, using Ghana as a case in this

study is significantly persuasive because, although Ghana was one of the first African countries to adopt far-reaching restrictions, there is a limited study, if any, that analyses the country's response to COVID-19 from biopolitical perspectives.

3 Theorizing the pandemic responses

The COVID-19 pandemic has thrown the whole world into hysteria, with academics racing to research the pandemic. There has been a remarkable eruption and profusion of scholarly contributions attempting to make sense of the responses to the COVID-19 pandemic. The study of the dynamics and response strategies of the COVID-19 pandemic has been of tremendous interest to the scientific community and governments. COVID-19 is possibly the most studied event in the 21st century. Arguably, every academic discipline has researched this pandemic (Højme 2022).

Many scholars have utilized theories of epidemics, such as *Chaos Theory* and *Behaviour Change Theories*, as material to speculate the responses to COVID-19. However, Michel Foucault's concept of *biopolitics* offers the opportunity to comprehend in great detail the choices of the Government of Ghana's response strategies to COVID-19. This paper does not contend that a Foucault-inspired approach can offer an exhaustive theoretical analysis of all political actions taken by Ghana's government to save lives from the pandemic. Instead, drawing on Foucault's *biopolitics* for the discussions in this paper, I seek to bring into sharper focus Foucauldian perspectives on responses such as lockdowns, quarantine, social distances, surveillance, and vaccination.

3.1 The Chaos Theory

Multiple theories and techniques have been deployed to model the epidemics of infectious diseases and policies implemented to contain the pandemic. One such epidemiological theory of containment as a response to the pandemic is Chaos Theory. COVID-19 has proven to be highly infectious with high mortality risk (Pazos and Felicioni 2020), and a single individual infected with COVID-19 is sufficient to trigger chaos. Chaos Theory is a branch of mathematics having practical applications in many disciplines, including physics, engineering, economics, and biology (Peckham 1967). Chaos Theory is the concept that a small change leads to a significant change in the future (Devaney 1989). Edward Lorenz introduced the phenomenon of Chaos Theory to the contemporary world (Lorenz 1993).

In Mount Vernon, Washington, one infected person spread the virus to 61 people who had met in a church for choir practice, leading to the death of two choristers (Hamner et al. 2020). A 29-year-old male in South Korea who visited nightclubs was connected to 54 new instances of the virus (Toronto Sun 2020). In China, nine individuals became infected with COVID-19 after being exposed to virus particles blown over their faces by an air conditioning vent in a restaurant. A single person likely caused the infection (Lu et al. 2020). Many analogous super-spreading scenarios have occurred in the COVID-19 pandemic. Small things could have changed the super-spreading outcomes discussed in the Chaos Theory. The clubgoer could have opted to watch television or hang out with a few friends on the street rather than go dancing. If the choir practice had been postponed to the next day, the individual might have felt ill and remained home. It was also possible to switch off the restaurant's air conditioning.

This paper analyses whether the COVID-19 responses have saved lives and how intrusive the policies have been. Although the Chaos Theory provides a successful control method (Wilding 1998), the method does not have the human population as the direct object of target, making the

theory less intrusive into people's lives. Besides, the Chaos Theory in itself suggests unpredictability. Disinfection of surfaces does not directly target the human body but likely contaminated surfaces that the human body may touch. Such a minor change may reduce the rate of spread but does little to flatten the curve of the infection rate. A change in weather conditions is an excellent illustration of Chaos Theory. As Sajadi et al. (2020) confirm, changes in weather conditions contribute to a significant change in the spread of COVID-19. Generally, we can anticipate weather patterns very well in the near future. However, as time progresses and more elements influence the weather, it becomes nearly impossible to foretell what will occur. Since the human body is the carrier of the virus, changes in weather conditions will do very little to stop the spread of the virus, so long as contact between people is not restrained or monitored. In this pandemic scenario, the application of the Chaos Theory proves insufficient for the containment of the disease.

3.2 The Behaviour Change Theories

Outbreaks of infectious diseases, such as the COVID-19 pandemic, pose a substantial threat to public health. The recorded cases of death from Ebola 2013-2016 (Aruna et al. 2019; CDC 2020), the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in 2012 (WHO 2019), and the H1N1 pandemic (CDC 2019; Dawood et al. 2012; Hine 2010) outbreaks are cases in point. In light of the trends of recorded high risks of pandemics, it is crucial to ensure health emergency readiness and resilience are enhanced to reduce or mitigate the impact of pandemic events. One such extensive strategy of mitigation is behavioural science.

The WHO emphasizes the significance of fostering adaptive and protective behaviour modification in response to public health emergencies and provides risk communication protocols to encourage people to act to protect themselves. The WHO echoed that human behaviour will dictate the rate of COVID-19 transmission and mortality, thereby making behavioural science central to the public health responses (Michie et al. 2020; WHO 2018). A myriad of behavioural science theories and models, such as the *Theory of Planned Behaviour* (Angus et al. 2013; Bish and Michie 2010; Corace et al. 2016; Westcott et al. 2017) and the *Commonsense Model of Self-Regulation* (Bish et al. 2011; Bults et al. 2015; Leventhal et al. 2003), were recommended and implemented as mitigating strategic response to COVID-19. Health professionals used theories of behavioural change to better comprehend and persuade people to take preventative measures in the face of public health crises (Weston et al. 2020).

While social distancing has been discovered as an efficient technique for flattening the epidemic curve, people struggle to suppress their innate need to speak and interact with others (Rigotti et al. 2020; Wollast et al. 2021). Social distancing behaviour is more challenging to learn and maintain because it is counterintuitive and unnatural. Willingly adopting such radical behaviour change, as proposed by the Commonsense Model of Self-Regulation, within a few days and for an extended period is difficult. Social contact habits like frequent hand-shaking, meeting, and hygiene behaviours are deeply embedded and hard to change (Wollast et al. 2021). Human beings are social beings and will not naturally alter such intrinsic values. There is no time to allow for behavioural change during pandemic emergencies. Behavioural change may work with diseases whose mode of transmission is slow.

Notwithstanding, it is not an impossibility to adopt particular behaviour necessary for health emergencies such as COVID-19. A planned behaviour such as hand washing can be predicted by a deliberate will to perform it (Ajzen 1991). Hand washing has been a prevailing social norm, making it easier to adopt as a COVID-19 pandemic emergency response. Admittedly, personal compliance with social distancing health behaviour is challenging compared to hand washing, which was already considered a habit. Arguably, decades of education on behavioural change in

terms of the use of condoms, abstinence, and avoidance of indiscriminate sex have not significantly altered the behaviour of many people as a common-sense-mitigating strategy for HIV/AIDS.

3.3 Why biopolitics?

The emergence of COVID-19 and its subsequent state responses have exposed the extent to which human biology and life itself have become subjects of governance. Even though the global pandemic is primarily being viewed as a health crisis in action with economic ramifications, it has also revealed the intrusiveness of even democratic regulations. Undoubtedly, the epidemiological and biological knowledge required to combat COVID-19 are concerns of professional health expertise. However, the application of this knowledge and the intrinsic capabilities of the health sector are not immune to politics. Like other crises, public health pandemics have a political life (Chigudu 2020). The boundaries between the human body and political power have become blurred, evidenced by rigorous government monitoring of the population. The monitoring is done through internet applications that track the health, behaviour, and movement of the population and the isolation of certain groups primarily defined by age and underlying medical conditions. The development of ‘immunity passports’, making biology the determining factor in one’s eligibility for certain benefits, has contributed to further blurring of the boundaries (Kalpokas 2020).

The term *biopolitics* describes the overlap and concomitant blurring of lines between biology and politics (Ailio 2017). The term *biopolitics* was probably first used by Rudolf Kjellén when he considered the state as a form of life. According to him, the behaviour and unity of the sovereign and constitutionality were an expression of life itself. Kjellén could not be far from right in his analysis of the geopolitical demands as something that stems from the instinct of life to secure and express its vigour and vitality through growth. Kjellén expressed the term biopolitics when he stated in his book *Great Powers* in 1905 that the sovereignty or great powers of the state are the most impressive form of life and, as such, should be the focus of ‘biopolitical research’ (Ailio 2017; Kjellén 1905:23, translated in Ailio 2017). Roberto Esposito (2008) also deployed the term biopolitics in his 20th-century political thoughts, which conceived politics as the continuation of life at another level.

Unlike the earlier briefly introduced biopolitical theorizations, Michel Foucault’s philosophy has become practically synonymous with how ‘biopolitics’ is understood and familiar to many scholars (Ailio 2017). The theoretical framework for this study is derived from Foucauldian conceptions of biopolitics. Contrasted with the other theories discussed, Foucault’s *biopolitics* offers a more nuanced perspective and a viable analytical framework for diagnosing the global responses to the COVID-19 epidemic. *Biopolitics* highlights the power relations shaping the scientific, medical, and technological governance of populations. In his late lectures at the College de France, Foucault uses biopolitics to describe mechanisms used to discipline bodies and regulate populations, including policies that control mortality. For Foucault, since the 18th century, biological life and the nation’s health became fundamental targets of power over life to optimize the biological quality of the population. To situate it in this study, Foucault’s social and political philosophy on biopolitics provides a conceptual framework for examining how countries have employed biopower technology such as lockdowns, social distance, quarantine, isolation, and contact tracing surveillance to discipline and manipulate populations in reaction to the threat of the COVID-19 pandemic. It is a concept that will be applied and deployed throughout this research as an analytical and explanatory tool.

Foucault theorizes liberalism in *The Birth of Biopolitics*, describing it as both a way to run the government and criticism of government, suggesting that the two events are inextricably linked. With this, sovereign power is transferred into ‘biopower’, which extends control over social

processes of the population and life itself (Anthrobiopolitics 2013; Foucault 2008). As Foucault writes in *Society Must Be Defended*:

I think that one of the greatest transformations political rights underwent in the nineteenth century was precisely that, I wouldn't say exactly sovereignty's old right-to take life or let live- was replaced, but it came to be complemented by a new right which does not erase the old right but which does penetrate it, permeate it. This is the right, or rather precisely the opposite right. It is the power to 'make' live and 'let' die. The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and to let die (Foucault 2003:241).

With this, the human species becomes the object of a political strategy or strategy of power (Sfetcu 2020). In such a scenario, life itself becomes a complex problem for the state to address. Biopower refers to the process through which a person's biological characteristics are turned into a tool of political manipulation (Foucault 2009; Nadarajah 2010). 'The purpose of biopower is to maximise life', but 'it also has a dark side' (Sfetcu 2020). Since the stakes are life itself, the state is justified to eliminate groups or life species considered threats to the nation-state's life (Foucault 1990).

Biopolitics considers how life and populations of a given region are regulated. Depending upon different circumstances, the population demonstrates dynamics of its own. For example, the population's fertility, mortality, morbidity, and life expectancy are all influenced by various factors. Consequently, the state's fundamental task is to rationalize the population and innovate population control techniques to protect the well-being of the 'body politic' (Ailio 2017; Foucault 2003).

What we are dealing with in this new technology of power is not exactly society (or at least not the social body, as defined by the jurists), nor is it the individual body... Biopolitics deals with the population, with the population as a political problem, as a problem that is at once scientific and political, as a biological problem, and as power's problem (Foucault 2003: 245).

Alternately stated, biopolitics takes population as its central concern, 'as a biological problem and as the problem of power' (Anthrobiopolitics 2013).

Biopolitics involves the form of government that regulates populations using biopower in every aspect of human life (Sfetcu 2020). Biopolitics is predicated on the idea that all life should be nurtured and developed to its fullest potential. This makes promotion and maximization of bios at the heart of biopolitics (Sfetcu 2020; Tolba and Unesco 2001). Foucault's *biopolitics* becomes the intersection between power and the individual's bodily autonomy (Schirato et al. 2012). Therefore, biopolitics extends state authority over biological and political life within a nation-state (Lemke and Trump 2011; Sfetcu 2020) and functions as an instrument of population control (Foucault 2003). According to Foucault, biopolitics is 'to ensure, sustain, and multiply life, to put this life in order' (Foucault 1990). Put succinctly, Foucault's *biopolitics* denotes social and political power over life, which produces a generalized disciplinary society (Foucault 2009). Like colonization, biopolitics is the strategy through which the colonizing authority uses political power to manipulate the colonized people (Said 1979). When Foucault alludes to biopolitics, he intends to demonstrate how the life of human beings as a species has become increasingly central in social and political decision making (Foucault 1978). Public health and health insurance, retirement pensions, public hygiene, public housing, social medicine, and welfare funds demonstrate how managing human existence has become a critical component of contemporary governance (Foucault 2003; Gudmand-Høyer 2008).

In the manner that biopolitics is understood today, Foucault argued that the leviathan's power to preside over the life and death of its population (Hobbes 1651) began to wane in the 18th century. This power of the state was largely replaced by the power to make live or let die (Ailio 2017). It must be understood that biopolitics is not only affirmative (to 'make' live) but also intrusive and involves abandonment (to 'let' die). The state's power acted on humans as biological beings by expanding the field of political power into man as a biological being. This is not to suggest that, according to Foucault, the life of subjects was irrelevant to the sovereign; instead, the question of life was raised more simplistically. After all, a large population formed the troops of the state army. On the contrary, Foucault's works on modern development culminate in the fact that the fundamental basis for the state's power is to consider the set of processes and management of the population (Foucault 2007).

Power is reflected in both social practices and human behaviour, and this is evident through the human acceptance of subtle regulations that ensure social order (Policante 2010). This newly enhanced regulatory power is what Foucault coined the 'biopower', which refers to the 'explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of population' (Foucault 1990:140). In this context, biopower is utilized to administer, modify, regulate, and maximize human life. Put differently, Foucault applies the concept of biopolitics to various forms of regulation, including those pertaining to public health. Similarly, in *Society Must Be Defended*, Foucault contends that the principal threat to modern societies is not another race or culture but rather any alternative to the dominant explanation of human biology (Foucault 2003).

In actuality, biopower becomes biopolitics—that is, the state's use of policies, such as mandatory medical examinations and annual paid leave to regulate the health of its citizens to ensure continuous availability of the labour force (Kalpokas 2020). As demonstrated by the preceding examples, such biopolitical measures are notoriously difficult to isolate and frequently appear to be beneficial during normal times. The COVID-19 pandemic has exposed the biopolitical regimes, revealing the extent to which states are willing to go to grip and invade the human body in order to maintain control over it. As the human body gets increasingly securitized, the reach of democratic repression broadens, mostly with popular support, as the ostensible reduction of bodily risk becomes the drawcard for profound subjection (Kalpokas 2020).

Concerning populations and governance in the current COVID-19 pandemic, academics emphasize the applicability of Foucauldian biopolitics in grasping regimes of truth while studying evolving biopolitical settings in the contemporary world (Lemke 2011; Rabinow and Rose 2006).

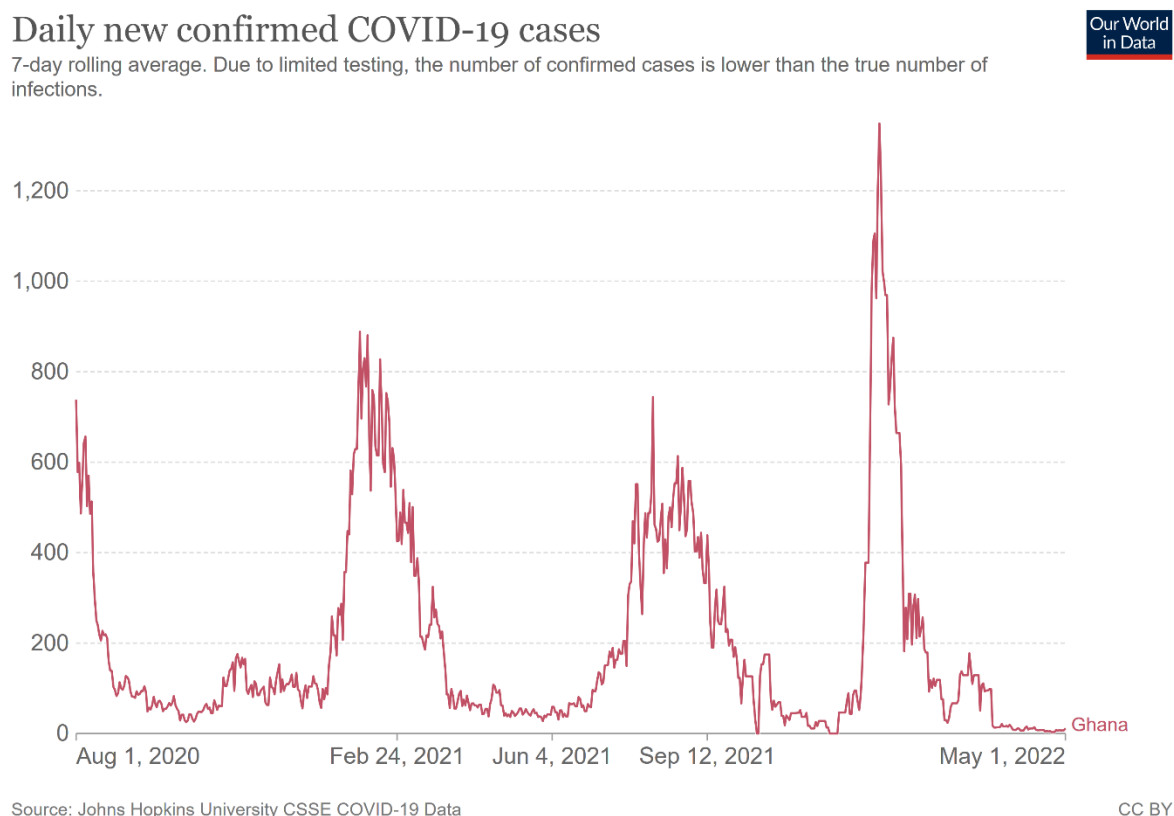
4 Ghana's effectiveness in governing the COVID-19 pandemic

What began as a remote outbreak in other parts of the world soon utterly shattered Ghana's sense of normalcy. The virus uncontrollably disrupted the regular routines of Ghanaians. The pandemic spread with startling rapidity, infecting millions of people worldwide and bringing the global economy to a standstill. The devastation of the COVID-19 pandemic to lives and economies was severe and significant. The COVID-19 pandemic has been much more than a health emergency. COVID-19 has had disastrous economic and social impacts on Ghana, although the health consequences of the COVID-19 pandemic have been less severe compared to other countries (Modernghana 2020). As of 21 May 2022, the Ghana Health Service COVID-19 Situation Dashboard showed 1,445 Ghanaians had succumbed to the virus out of a total of 161,370 confirmed cases with 159,881 recoveries, putting the number of active cases at 44 (GHS 2022). This success has been mainly due to the government's decisive, innovative, and swift crisis management. Ghana's success story in protecting the lives of Ghanaians from the plague of

COVID-19 cannot be attributed to mere luck. According to Fukuyama (2021) and Gisselquist and Vaccaro (2021), state effectiveness has been one of the primary determinants of successful pandemic responses.

Similarly, Ang (2020) highlights that *state capacity* to implement solutions has driven successful pandemic responses, while Asante (2022) credits Ghana’s *residual capacity* for successful pandemic responses. Ghana’s capacity and effectiveness were necessary for implementing the various COVID-19 response protocols in line with the Foucauldian framework. From the start of the pandemic, the government of Ghana established an Inter-Ministerial Committee to halt the spread of COVID-19. The committee’s chairman, President Nana Addo Dankwa Akufo-Addo, quickly announced several measures to stem the spread of COVID-19 (Danquah and Schotte 2020).

Figure 1: Daily new confirmed COVID-19 cases, August 2020–May 2022



Source: Our World in Data (data sources indicated in the graph), reproduced under the Creative Commons license CC BY 4.0.

Ghana’s president addressed the nation a day after WHO declared COVID-19 a pandemic. He assured that all entry points, including land borders and airports, were ready to screen incoming travellers. The president reaffirmed that everyone must observe the COVID-19 social distancing protocol to prevent the spread of the disease. He emphasized that the struggle was not solely the government’s responsibility but required the participation and cooperation of all parties involved (K. P. Asante 2020). Even before Ghana could fully understand the impact of the COVID-19 outbreak, protecting the lives and livelihoods of the people was the top priority. The president quickly announced initial plans to spend US\$100 million as part of Ghana’s prescient readiness (Ministry of Finance 2020). The plan established the groundwork for implementing actions to save lives and safeguard the economy from recession. Ghana had its first two cases on 12 March 2020 from passengers arriving from Norway and Turkey. Following the discovery, Ghana adapted

responses from the WHO guidelines coupled with existing domestic public health emergency guidelines. Six overriding principles guided the responses.

4.1 Constitutionalism

Pandemic response decisions were made within the ambit of the Constitution of Ghana and other available legal infrastructure beyond which executive instruments (EIs) we passed. The president of Ghana passed EIs to give legal backing to the COVID-19 containment strategies and directives. The EIs were E.I.63 on Establishment of Emergency Communications System Instrument, 2020. The president invoked this Act under the power conferred by Section 100 of the Electronic Communications Act, 2008 (Act 775). This Act granted powers to the president to order operators or providers of electronic communications networks to provide the government with subscribers' details to trace all contacts of persons suspected of or affected by COVID-19.

Pursuant to Act 1012 (2020), the Imposition of Restrictions Instrument (EI 64) was invoked to provide for the wearing of face masks, face shields, or any other face covering that covers a person's nose and mouth completely when that person is in a public place or leaving or returning to their place of residence. The EI allowed the president to restrict fundamental freedoms according to clause (4) of Article 21 of the Constitution of Ghana (Hagan 2020).

Pursuant to Section 169 of the Public Health Act, the Minister of Health invoked Act 851 (2012), which grants the Minister of Health the powers to implement appropriate policies in emergency public health situations. These legal instruments provided the basis for the lockdowns, social distances, contact tracing, quarantines, isolations, mandatory wearing of face masks, and vaccination.

4.2 All government approach

Ghana's health delivery system has improved slowly over the years with lacklustre general performance (Abdulai 2018). The Global Health Security Index ranked Ghana 105 out of 195 countries (Cameron et al. 2019). Ghana had only 16 operable ICU beds across nine facilities in February 2020, with 0.5 ICU beds per 100,000 people (Siaw-Frimpong et al. 2021). However, Ghana overcame its weak capacity and under-resourced public health system by leveraging the proactive (sub) regional coordinated response and the residual capacity developed through prior public health programmes (K. T. Asante 2022).

In 2019, Ghana's government procured 307 ambulances to replenish the existing stock. The government distributed the ambulances to the various district, regional, and teaching hospitals two months before the country recorded its first cases of COVID-19 (ISSER 2020). There was a collaboration between the Ghana Health Service and Zipline to incorporate a drone delivery system into the country's national COVID-19 response strategy to deliver medical supplies to remote parts of the country. Ghana became the first country globally to use drones to deliver COVID-19 vaccines (León 2020; Nwannekanma 2021; Vincent 2021). Health experts were generally optimistic that the existing state capacity would contribute to saving money and lives. In partnership with African Union (AU), the number of testing labs in Ghana expanded from three to 43 between February and mid-March 2020. In addition, surveillance capacity at entry points was bolstered to prevent and contain infections (Africa CDC 2021; Loembé et al. 2020).

All ministries and government agencies were involved in containing the novel ravaging virus. The president established and chaired the National COVID-19 Task Force. The president appointed a National Coordinator and activated public health emergency management committees in all Metropolitan Municipal and District Assemblies. A National Technical Coordinating Committee

and a National Emergency Operation Centre (EOC) were also instituted to oversee the health sector actions.

The National Technical Coordinating Committee included the President's Advisor on Health (Dr Anthony Nsiah-Asare), a former Deputy Director-General of the WHO (Dr Anarfi Asamoah-Baah), and the then-newly appointed Deputy Minister of Health (Dr Okoe-Boye), who came from a medical and public health background, replacing one with a legal and financial background. The EOC was activated within four thematic activities: surveillance, case management, risk communication, and laboratory.

4.3 All society approach

Since the onslaught of COVID-19, the Ghanaian government has also worked with faith-based organizations, market women, public transport owners, pharmaceutical manufacturers, industry leaders, and legislators to improve public education, expand infrastructure, and expand local manufacture of personal protective equipment (PPE) and other materials. On 4 April 2020, the president convened a meeting with opposition party leaders to discuss the COVID-19 outbreak. In collaboration with faith-based organizations, the government provided cooked and dry food packs to vulnerable persons within the catchment area of the lockdown. This was in addition to a cash transfer of GHS50,200,000 to 400,000 of the most-vulnerable individuals under the Livelihood Empowerment Against Poverty (LEAP) programme (A. Ibrahim 2020).

Individuals and groups donated money and goods upon discovering COVID-19 in Ghana. Some gifts went to hospitals, prisons, and the poor, while others went to the government. The president appointed a Board of Trustees to supervise the donation of funds. The president and vice president pledged their April–June salaries to the fund, while some parliamentarians gave half their April–June salaries (Ansah 2020). Following the National Fund's footsteps, local leaders in some areas also established support funds to assist the less fortunate. On 1 April 2020, Otumfuo Osei Tutu II, the Asantehene, established a One Million Ghana-Cedi COVID-19 fund that also inspired Asanteman Europe, an association of Asantes in Europe, to donate over EUR23,000 worth of PPEs to testing institutions and other frontline workers in hospitals (Baah 2020; Mensah 2020).

Ghana's COVID-19 responses involved continuous engagement with all facets of society, from academia, traditional rulers, religious rulers, and scientific and civil society, to explain the government's choices in fighting the pandemic. The Ministry of Information had a long tradition of holding periodic press conferences headed by the Minister of Information. The Ministry of Information led a two-weekly briefing on COVID-19 with the Ghana Health Service. Materials for public education were translated into eight indigenous languages using skits, jingles, and social media influencers to improve coverage. There were regular updates by the president of Ghana, now nicknamed 'Fellow Ghanaians'. The president's regular update was nicknamed 'Fellow Ghanaians' because he always started his speech with that phrase. The president gave his 27th televised update on 27 March 2022, where he relaxed most protocols because cases had gone down.

4.4 Science and data

The responses were guided by evidential data based on research from medical, political, social, and economic sciences. Ghana also learned from the experiences of other COVID-19-affected countries and engaged schools of public health, the Ghana Academy of Arts and Sciences, and professional bodies. The Ghana Health Service (GHS) led the fight against the COVID-19 pandemic and influenced government choices. The GHS promoted public awareness of COVID-19 prevention, testing, and treatment in collaboration with the Ghana Medical Association.

Ghanaian telecommunications companies assisted the GHS in obtaining contact information. COVID-19 was monitored in real-time online by the GHS. Additionally, it guided the government regarding COVID-19 contact tracing and management methods. On 26 April 2020, in response to conspiracy theories spread by some media outlets during this outbreak, the president urged reporters to let ‘the science speak for itself’ and refrain from propagating fake news.

The government proactively instituted a US\$100 million National Emergency Preparedness and Response Plan (EPRP) for COVID-19 to assist in managing and containing the spread of the virus and bolster national capacity for surveillance, diagnosis, and case management (BBC 2020; Ministry of Finance 2020). The Noguchi Memorial Institute for Medical Research (NMIMR) at the University of Ghana, the Kumasi Centre for Collaborative Research (KCCR), and the National Public Health Reference Laboratory at Korle-Bu Teaching Hospital were designated as national testing institutions. Within six weeks of the first case in the country, Ghana expanded its testing institutions from three to 10. The government provided PPE and life insurance for all frontline health workers. The government of Ghana further incentivized frontline workers by waiving personal income taxes, offering an allowance of 50 per cent of the basic salary, and providing transportation for frontline workers throughout the lockdown period. Given resource constraints, scientists at the University of Ghana’s NMIMR developed an innovative batch-testing system (Owusu and Crentsil 2021). This cost-effective strategy allowed Ghana to scale up testing significantly. By the end of May 2020, the country ranked way above the SSA average in terms of the testing rate and was second only to South Africa, the hardest-hit country on the continent.

4.5 Ghana beyond aid

Ghana recognized an inherent opportunity to inspire the expansion of domestic capabilities and deepen self-reliance when basic PPEs were in short supply. Within 48 hours after announcing the first two cases of COVID-19 in Ghana, 37 companies turned their existing factories to produce enough sanitizers and masks. The government supported the production of face masks, solar-powered hand-washing machines, surgical gloves, scrubs, and other PPE by some local businesses. The Ghana Standards Authority and the Food and Drugs Authority tested and certified all domestically manufactured products.

Scientists at Kwame Nkrumah University of Science Technology (KNUST) and other institutions made alcohol-based hand sanitizers for distribution throughout the country (Ghanaian Times 2020; Nkansah 2020). KNUST’s College of Engineering built Infectious Bronchitis Virus (IBV) ventilators (KEEP News 2020). Additionally, KNUST scientists collaborated with Incas Diagnostics to produce a rapid diagnostic test kit for COVID-19 (Mastercard Foundation 2020). The vice president of Ghana launched the Ghana COVID-19 Tracker App and a similar app, TECHBOT, developed by KNUST for contact tracing (ITU News 2020; KNUST 2020).

While the Noguchi Institute of Medical Research and the KCCR were initially allocated for COVID-19 testing, rising demand prompted the building of eight additional testing facilities throughout the country. The private sector involvement in the COVID-19 response was heavy. The private sector built an infectious disease treatment centre with a 100-bed capacity in Accra within 100 days. Other centres across the country were built with the assistance of the commercial sector and faith-based organizations. In April 2020, Zipline Company, which operates medical drones in Ghana, began transporting COVID-19 test samples in April 2020 to minimize the time between sample collection and testing in remote regions (León 2020).

4.6 Consistency

The initial response to the COVID-19 pandemic in Ghana was swift, decisive, and consistent, contrary to the inertia and reluctance that characterize the response in Europe and the United States. While the European unit of WHO advised using lockdowns as a last resort due to the collateral harm they could cause (Ibbetson 2020), Ghana began applying the WHO's COVID-19 guidelines after only two cases were documented. Ghana's situation could have been worse if it had followed the path of Sweden. The Swedes gambled with the virus by using a softer approach that favoured herd immunity at a time when Ghana had locked down its epicentres and had deployed the police and military to enforce the directive and regulate violations of the lockdown measures (Irwin 2020; Vogel 2020).

According to Columbia University disease modellers, fewer people would have died if the United States had begun imposing social distancing measures one week earlier than it did in March. If the country had started locking down cities and limiting social contact early, 83 per cent of deaths could have been avoided (Glanz and Robertson 2020).

European Union (EU) member countries, in particular, were reluctant to close their borders, which have remained open for decades, for fear of creating a sense of a 'New Berlin Wall'. Though many European countries delayed imposing lockdowns, they were the first to reopen their borders and lift lockdowns. Whereas many European countries began to experiment with the opening of their borders as early as April 2020 in the hope of reviving their national economies against cautions by health experts (Godin 2020), Ghana's land borders continued to be locked two years after President Akufo-Addo closed all borders until the end of March 2022 while strict COVID-19 testing measures continued to be in place at the airports (Africa News 2022). Again, whereas Europe has long abandoned the COVID-19 vaccine mandate, at least within the EU, travellers without negative PCR tests are denied entry through Ghana's land, sea, and air borders unless the person is fully vaccinated.

5 Immanence of biopolitics of pandemics

In this section, the paper discusses Ghana's various biopolitical measures and analyses their effectiveness in the fight against the COVID-19 pandemic. This section further analyses the extent of intrusiveness of the biopolitical approaches to individual freedoms and how the crisis was manipulated to legitimize a state of emergency to give more power to the executive branch of government.

5.1 Lockdown, social distance, and quarantine

From the onset of the crisis, different countries adopted different response strategies, with health experts and officials struggling to agree on what counts as death from the Coronavirus disease (Sfetcu 2020). Soon, it was clear that case detection, contact tracing, selective isolation, and quarantine were insufficient to stop the spread of COVID-19 (Haider et al. 2020; Strategy and Policy Working Group for NCIP Epidemic Response, Chinese Center for Disease Control and Prevention 2020). China's strategy to battle the Coronavirus was criticized by the Western media as extremely harsh and did not provide any assurances of success (Qin et al. 2020). China's controversial, crude, and severe lockdown strategy became the international norm after many countries had gone through difficult experiences (Caduff 2020). Lockdown became the dominant response to the spread of COVID-19 in high-income countries. The household-level economic situation in most parts of Africa was at odds with the demands of a lockdown (Bell 2020; World

Bank 2020). Lockdowns required people to stock up on food and other essential products to survive at home. Most households in sub-Saharan Africa rely heavily on subsistence income from working in informal sectors and mostly live hand-to-mouth. There were concerns that people might die out of hunger from lockdowns before the virus reached them, making the chances of contracting the virus less threatening than starvation (Khullar 2016).

There were fears that attempts by developing countries to adopt lockdown policies from rich countries may cause irreversible harm to households and perhaps spark civil instability (Egger et al. 2020). Most African households were not prepared for lockdown. Egger et al. (2020) define lockdown preparedness as the capacity of households to remain at home without suffering irreparable harm to their health and wellbeing. A 2019 Afrobarometer survey spanning 30 African nations shows that just 6.8 per cent of all families and 12.2 per cent of urban households match all the criteria for a lockdown (Afrobarometer 2019b). Many people in sub-Saharan Africa must leave their homes daily to get clean water, sanitation facilities, food, and employment. Many families have little or no savings from working in the informal sector, and it is impossible for people who live hand-to-mouth and work in the informal sector with little or no savings to stay at home. The lockdown responses severely affected the poor in crowded urban cities without savings (Dingel and Neiman 2020; Ebrahim 2020; Raju and Ayeb-Karlsson 2020; Sen 2020).

In most parts of Ghana, living conditions were incompatible with the concept of lockdown and social distance. Experts urged a complete lockdown to eradicate community spread at the two epicentres, but the government was faced with the problem of the inconvenience it would cause the poor and the economic repercussions of the stimulus packages. People in slums and other unplanned communities live in close quarters and must share essential utilities such as water and bathrooms. Under such living conditions, avoiding contact to prevent the spread of COVID-19 was practically impossible. Despite the overwhelming evidence of the catastrophic impacts of unplanned lockdown, Ghana ordered a lockdown in its two largest metropolitan areas for three weeks (Khoo 2020). The government closed schools and businesses and prohibited various public and private gatherings. The lockdown in Ghana was similar to what happened in South Africa (Dzobo et al. 2021); Uganda (Matovu et al. 2021); Nigeria (R. L. Ibrahim et al. 2020); and Sudan and Sierra Leone (Haider et al. 2020) with disproportionate lengths, peculiarities, and durations.

When Ghana contemplated the lockdown policy, many households in the urban cities of Ghana did not meet all the five minimum criteria for lockdown readiness as prescribed by Aghajanian et al. (2020). The criteria were: (1) safe drinking water; (2) basic sanitation; (3) reliable energy; (4) a means of communication (e.g., a mobile phone); and (5) a form of employment that provides sufficient savings to be able to survive at home without going out. To meet the minimum criteria for lockdown readiness, the government fully covered the cost of water and electricity consumption for one million lifeline customers and subsidized 50 per cent of the consumption of all other customers from April to June 2020 (Ofori-Atta 2020). The government offered vulnerable individuals within the regions of the lockdown prepared and dry meal packs. This was in addition to the LEAP programme's payment of GHS50.2 million in cash to 400,000 of the most disadvantaged citizens. Considering the subsistence nature of the economy, markets were not locked down. However, the market had to be decongested by making businesses and petty traders rotate the use of the market. People within the lockdown catchment areas could go to the market and other essential places. Further, the government supported small and medium-sized businesses with a soft credit programme of up to GHS600 million in partnership with the National Board of Small-Scale Industries, Business, and Trade Associations and selected commercial and rural banks.

The government had no better choice than to institute disciplinary controls such as lockdowns and quarantines to manage the pandemic. According to Foucault, such responses constituted attempts to maximize the population's health, life, longevity, and strength. In addition, he asserts

that the purpose of keeping a healthy population is to increase wealth and productivity for consolidation of political dominance (Tasnim 2021). The government of Ghana took a keen interest in keeping tabs on the health of its population. The state's sovereignty was no longer limited to land and what it generates but extended to include additional responsibilities for people's bodies and actions (Baldwin 2005). The movement of people's bodies became a major concern because 'the virus moves when the people move'. Lockdowns, social distances, and quarantines became the most valuable items in the toolbox in responding to the virus. With the shift from traditional sovereignty, 'political power took over care of the biological life of the entire social body' (Foucault 2003:366). Regulation of citizens as biological species was vital to the state's existence, as opposed to just defence and economy (Gastaldo 1997). The state then implemented lockdowns and social distance measures to manage and optimize life.

As Salter writes, 'The history of the body politics is inextricably intertwined with the history of the political body' (Salter 2006:178). This statement concisely encapsulates Foucault's conception of biopolitics (Foucault 2009). Foucault contends that modern states are increasingly fascinated with the confluence of power and human biology, to the point where human health has begun to play a part in conceptions of power, ultimately becoming a type of power itself (Foucault 1977; Youde 2019). The state becomes concerned not only with what the bodies represent but also with the bodies themselves. The emergence of biopolitics is where states obtain control over individuals as biological entities instead of merely political subjects. Biopolitics focuses on the entirety of the human population. Biopolitics represents the expansion of state power, as the state now strives to adopt laws that regulate the physical wellbeing and health of the population (Turner 2006).

Throughout the pandemic, governments exercised control by fostering habits such as hand washing and social distancing to promote the physical and moral health of the entire population. It shows how the government attempts to control the fertility, mortality, and morbidity rates of the population. In addition to population size and quality, biopolitics looks at fertility rates and ties within families (Sachs 2005). Even though these practices appear to benefit people, they serve the state's objectives and quest to increase its security and economic prosperity.

Foucault relates this disciplinary mechanism to the design of the ideal prison named 'the Panopticon'. The philosophy of panopticism can be traced intellectually to Jeremy Bentham. In 1785, he designed a prison that allowed guards to observe all prisoners at any time, without the prisoners being aware. There is a single tower from which the jail guard could observe all of the cells and the behaviour of the inmates. Bentham believed that the potential of surveillance would inspire prisoners to supervise their own conduct and behave appropriately at all times, as the prisoners do not know when they are being watched. Foucault extended this concept to every facet of society, including schools, churches, hospitals, and airports, and argued that the concept of the Panopticon is no longer restricted to prisons. These institutions discipline the population implicitly even if (seemingly) no one is exercising express power. The population, like prisoners, attempted to conform to the new normal by internalizing government-suggested behaviour. People regarded the social distance, lockdown, and quarantine measurements as normal due to the daily exercise of disciplinary power, and those who thought outside the structure were deemed deviants. When the government of Ghana imposed lockdowns and ordered the people to ensure physical distancing, the government did not have to deploy national security to follow every individual or stand at door posts of citizens to ensure compliance. As Harari is quoted in *Dataethics*:

When people are told the scientific facts, and when people trust public authorities to tell them these facts, citizens can do the right thing even without a Big Brother watching over their shoulders. A self-motivated, well-informed population is usually far more powerful and effective than a policed, ignorant population....But to achieve such a level of compliance and cooperation, you need trust. People need

to trust science, to trust public authorities, and to trust the media (Dataethics 2020; Harari 2020).

Non-state actors such as Amnesty International and Human Rights Watch use panoptic surveillance for the common good, as examined by Steele and Amoureux (2006). These organizations use this strategy effectively to prevent human rights violations and genocide. They represent more fluid and swift power structures than sovereign governments with hegemonic power (McNeil 1998).

The lockdown imposed disproportionate limitations on personal freedoms, civil liberties, and democratic norms. The military and police were enlisted to assist health authorities in expediting the expansion of contact tracing capabilities (Danquah and Schotte 2020). During the initial stages of the lockdown in Ghana, there were isolated instances of reported violence and clashes between armed security personnel and individuals, including a journalist who violated lockdown regulations (African News Agency 2020). However, most of the videos about police abusing citizens during the lockdown period proved to be either unrelated or old, with some dating as back to 2013 (Ghanaweb 2020a). Section 6 of Act 1012 makes it a crime to violate the restrictions established by the issued EI. A violation of this section is punishable by a fine of between 1,000 and 5,000 penalty units, or between 4 and 10 years in prison, or both, upon summary conviction.

5.2 Pandemic biosurveillance and securitization of health

This section explores biopolitical health surveillance, highlights the concerns it raises, and identifies possible potential benefits associated with increased health surveillance. The pandemic and measures used to contain the virus have brought the government's biopolitical practices into a much sharper focus than before, as they create avenues for enhanced surveillance, particularly when such mechanisms differentiate across sections of the population (Sylvia 2020). Biopolitics provides an important prism for viewing the surveillance of the COVID-19 epidemic. The dread of the pandemic has created a sense of insecurity in many facets of life, including alterations in interpersonal relationships (Faro et al. 2020; Santos et al. 2022). Agamben, who applies the concept of Foucault's *biopolitics* in his writings, expresses concern about the growing tendency to use the state of emergency of the COVID-19 pandemic as a standard paradigm of government through securitization of the people and areas proven to be infected. The pandemic emergencies have imposed restrictions on freedoms that are mostly disproportionate to the real threat of the pandemic (Agamben 2020a). Žižek has expressed fears of 'human-faced barbarism' in the fight against the pandemic based on expert advice. He argues that COVID-19-related messages and strategies undermine the foundation of our social ethics (Žižek 2020a). The strike of the pandemic did not usher the world into a Hobbesian natural state, despite the absence of theatre, concerts, travel, and sporting events (Bufacchi 2020). However, we began to see what Hobbes referred to as the 'war of all against all': Countries fiercely competing on the global market for Coronavirus personal protective gears 'and which is worst of all, continual fear and danger of violent death; and the life of man, solitary, poor, nasty, brutish, and short' (Hobbes 1651; Kroustallis 2014; Sfetcu 2020).

As Agamben puts it, the pandemic provided the ideal pretext for expanding the restrictions and protocols beyond any limitations, just as in the case of terrorism. Thus, in a vicious cycle, the restrictions on freedom by the government are embraced in exchange for security, a situation created by the government and being resolved by the same government (Agamben 2020a). Reading Agamben, it is problematic to accept that the security emergencies have been created outside of the pandemic. This paper argues that the pandemic itself and the response to the pandemic by the population create political and scientific problems for securitization. The restrictions on freedom are not for its sake but apparatuses to maximize life.

Infectious diseases have moved from being a health concern to national and global security threats (Fairchild et al. 2007). The kind of fear and anxiety generated by the Coronavirus is similar to terrorism. The COVID-19 terror has not only toppled daily life, but it has also separated people from one another and caused paralysis in the economy. The engendered fear of the unseen Coronavirus has brought emptiness to streets, restaurants, and shops while instilling global agoraphobia. COVID-19 has seeded death in the thousands and turned hospitals into triage wards.

Terrorism aims to terrorize, but the COVID-19 terror is not only more frightening and widespread but also impermeable to military surveillance and SWAT teams' responses and cannot be impressed by rhetoric or threats. After the 11 September terrorist attack on America, the President of the United States, George Bush, encouraged Americans to go about their normal lives, work, travel, and board aeroplanes (Feaver 2013). Similarly, French President François Hollande led marches to demonstrate the public defiance, resilience, and solidarity after the attack of Charlie Hebdo in France in 2015 (BBC 2015). The COVID-19 terror requires a distinct kind of solidarity. The public does not have to show their resilience to the terror of the virus through large gatherings, getting on planes, and going about their everyday lives. To be resilient now is to be locked down and stay home.

In a pandemic emergency, most people are unreservedly willing to sacrifice everything to avoid the dangers of sickness and death. People are practically prepared to avoid others and even ignore what happens to the dead bodies of their loved ones (Agamben 2020c). With the population in countries becoming accustomed to living in this way, what will become of human relations and society whose only value is survival? It is tempting to agree with Agamben when he opines in his *Clarifications in Quodlibet* that:

Men have become so used to living in conditions of permanent crisis and emergency that they do not seem to notice that their lives have been reduced to a purely biological condition, one that has lost not only any social and political dimension but even any compassionate and emotional one. A society that lives in a permanent state of emergency cannot be a free one. We effectively live in a society that has sacrificed freedom for so-called 'security reasons' and, as a consequence, has condemned itself to living in a permanent state of fear and insecurity (Agamben 2020b).

Agamben opines in *Biosecurity* that 'It is legitimate to ask whether such a society can still be defined as human or whether the loss of sensitive relationships, face, friendship, and love, can be compensated for by an abstract and supposedly completely fictitious health security' (Agamben 2020c). Slavoj Žižek admits the ineffectiveness and inefficiency of the COVID-19 pandemic protocols and how authorities hide and manipulate the accurate data but is quick to question why state power would be interested in promoting such fear that has the propensity to create mistrust for state institutions and cause economic disruption without a justification (Žižek 2020a). Agamben wonders whether any society that compensates for losing intimate relationships, face, closeness, and friendship with supposedly fear-mongering and fictitious health security can be considered human (Agamben 2020c). However, Agamben's statements in opposition to the COVID-19 security and restrictions have been described as mere paranoid vituperations and pure exaggerations (Peters 2020), particularly with emphasis by Jean-Luc Nancy in *Viral Exception* that 'We must be careful not to hit the *wrong* target: an entire civilisation is in question, there is no doubt about it. There is a kind of viral exception - biological, computer, cultural - that is pandemic. Governments are nothing more than gloomy executors, and questioning them seems like a diversionary ploy rather than a political reflection' (Nancy 2020). As De Carolis argues, no organic life exists in isolation from the risk of illness and death, just as no social life exists in isolation from the risk of transmission. Thus, we must question ourselves to what degree we are willing to forego

our own safety, and potentially even our own biological security, in order to have dinner with a friend, hug a child, or just walk down the street and talk with friends. Where do we draw the boundary between social and physical wellbeing? Which is more critical: our social happiness or our health (De Carolis 2020)?

Governments worldwide have been increasingly using data to enforce social distancing measures. The use of location data has been the most common method of collection (Sylvia 2020). The increased access to the internet and various communication channels and devices provide new prospects for surveillance that lead to a significant increase in social control (Briggs and Nichter 2009). Modern technology, including mobile phones in China (Elegan and Chandler 2020) and facial recognition in Russia (Ball 2020), already permits nearly complete pandemic surveillance. While police in Tunisia used robots, India employed the use of drones (Jawad 2020; Poovanna 2020).

Meanwhile, South Korea used smart wristbands for monitoring (Cole 2020). Drones were used by both China and the United States to assist in tracking the progression of COVID-19 and further employed drones equipped with loudspeakers to enforce social distance regulations, with China using drones to carry QR codes to vehicles passing through checkpoints. Drones equipped with Draganfly software were used in Westport, Connecticut, to track vital signs like body temperature, heart rate, and breathing irregularities (Novak 2020a, 2020b; Sharma 2020; Sylvia 2020). Apple and Google worked together to create an application programme that other applications can use for contact tracing (Morley et al. 2020). Taiwan's National Communication Commission developed a geofencing system based on cell phones targeting quarantined users (Hui 2020). The system analyses mobile phone locations and notifies authorities when a signal breaches the geofence. The Africa Union's Africa Centre for Disease Control (ACDC) encouraged biosurveillance technologies in response to the pandemic. Whereas the application of location-based surveillance is not novel, its use during the pandemic sparked privacy concerns.

The Africa Union's ACDC encouraged using biosurveillance technologies in response to the pandemic. The AU backed using PanaBios, a Pan African technology, to track the spread of the virus and connect the COVID-19 testing centres across the continent without a data privacy policy that meets the data protection laws of subscriber countries. Ghana was among the first countries to use PanaBios when it started easing restrictions at its borders (Yeboah 2020). This was to ensure test results from other countries satisfy port clearance requirements in Ghana. Ghana enacted new legislation authorizing the president to exercise emergency powers to combat the pandemic by requiring telecom companies to provide personal customer information to track the contacts of Coronavirus cases using a COVID-19 Tracker App.

The government used COVID-19 to increase its powers. Ghanaians were open to accepting some restrictions of freedom in terms of movement. However, they generally did not support restrictions that affect democratic norms such as elections and human rights. The inability of countries to secure cooperation from the people in adhering to the social distancing measures contributed to the further spread of the virus, particularly in the crowded cities of Accra and Kumasi. The government has to deploy police in the military to ensure the closure of churches and theatres and social distancing at marketplaces and beaches. Many people agreed the government must use security forces to restrict movement, but others opposed the use of surveillance technology to monitor their movements.

The COVID-19 Tracker App used telephone-related data to trace contacts of COVID-19-infected people and individuals who had been in contact with an infected person and connect these individuals with health specialists for immediate action. The app also reported individuals who came to Ghana from COVID-19-affected countries. In defence of the COVID-19 Tracker App,

the vice president, the Daily Monitoring Team Chairman for COVID-19 in Ghana, said, ‘You cannot fight what you cannot see’. ‘In the fight against COVID-19, data is our most powerful weapon’ (UN/ITU 2020). Contrary to the popular view of COVID-19 as an epidemiological disaster, the national security implications of the pandemic are far-reaching. This makes it critically imperative to assess the lessons of this zoonotic pandemic in terms of Ghana’s health surveillance systems to protect populations from COVID-19 and the intrusiveness to the population’s rights. EI 63, which allowed the government to collect personal data of telephone subscribers pursuant to the Electronic Communications Act, 2008 (Act 775), was unsuccessfully challenged in a high court in Accra (Dzawu 2020; Yeboah 2020). The deployment of COVID-19 infection and contact tracing applications and technology allowed the government to exercise biopower over the population.

Generally, the media landscape in Ghana is not censored by the government, but there was subtle surveillance on access to the internet during the pandemic. The people’s unhindered access to the internet provided new forms of knowledge about COVID-19 pandemic management and treatment. The easy access to the internet empowered the population and offered challenging illusions of agency, and the people were overwhelmed by the overabundance of information. However, access to the internet, other communication devices, and platforms also provided new avenues for government surveillance, contributing to social control. The overabundance of communication networks and devices increased the opportunities to exercise biopower in a neoliberal society.

The abundance of the internet provided an opportunity for government officials to monitor the activities of the population relative to COVID-19. What websites are visited by the population, and what kind of health information is circulated? This unseen interaction between officials and the population created panopticon-like surveillance (Briggs and Nichter 2009). On the other hand, the internet provided inverse synopticon-like surveillance of state activities by the population. The new form of technology and media offered the population the opportunity to monitor the activities of state officials and health experts. The Minister of Health was embarrassed when documents detailing the payment of US\$2,850,000 to Sheik Ahmed Dalmook Al Maktoum of the United Arab Emirates, a middleman in a controversial procurement of 3.4 million doses of the Russian Sputnik V vaccine, surfaced on the internet. The Minister of Health had earlier denied knowledge of any payment when he testified before an ad hoc Committee of Parliament, where he had said, ‘to the best of my knowledge, we haven’t done any payment’ (MyJoyOnline 2021). Influential people working with the management of the COVID-19 pandemic were afraid of media surveillance of their activities that may uncover incriminating information about them, which has helped to ensure transparency. As argued by Thomas Mathiesen, surveillance has developed beyond Foucault’s panopticon model (Mathiesen 1997).

Beyond the pandemic, these tactics will continue, expanding abusively to include spying on political opponents and stifling dissent. As a result, the pandemic will profoundly alter how information services are delivered. Yuval Noah Harari recently wrote in the Financial Times:

As a thought experiment, consider a hypothetical government that demands that every citizen wears a biometric bracelet that monitors body temperature and heart rate 24 hours a day. The resulting data is hoarded and analysed by government algorithms. The algorithms will know that you are sick even before you know it, and they will also know where you have been and whom you have met (Harari 2020).

Several technological advancements have been recognized for their role in containing the spread of COVID-19. From this vantage point, during a pandemic, people may tolerate some level of

surveillance procedures that they normally would not. Foucault did not think of power, particularly biopolitical power, as intrinsically harmful but rather as something that is constantly shifting and evolving in response to changing circumstances. Understanding the risks associated with such surveillance precedents and their broader implications for population subjectivation processes is critical. After COVID-19 has become less life-threatening or the end of the pandemic, it is likely that both authoritarian and democratic governments may continue to employ surveillance measures to control the people (Sylvia 2020).

As warned by Gisselquist and Solanki in *The Conversation*, the primary danger is that these technologies will survive the pandemic and be used to monitor and control populations indefinitely (Solanki and Gisselquist 2020). Along with the erosion of rights and a weakening of democratic institutions, these new surveillance techniques raise grave concerns about the future. Ghanaians must either accept that the newly found biopolitical power over the securitized body is the new normal or reject its intrusiveness and the idea that the body can be governed without risk (Kalpokas 2020).

6 Democratization crisis under COVID-19

COVID-19 has affected democracy (Lührmann and Rooney 2020) in many parts of the world. From the onset of the COVID-19 pandemic, democratic values and human rights have deteriorated in 80 countries (Pillay and Madzimore 2021; Repucci and Slipowitz 2020). Some governments responded to COVID-19 through abuses of power, suppression of their opponents, and weakening of critical institutions to undermine the accountability systems required to safeguard public health. The pandemic of COVID-19 has sparked more crises for democracy throughout the world. Given the rapid outbreak of the pandemic and the severe health dangers it posed, it was not always unreasonable or unjustified to postpone elections. There are many failed and successful attempts by the governments to postpone general elections under the pretext of the COVID-19 pandemic to extend their tenure and take more control of the state (Cassidy 2020). The political systems of several countries have also been disrupted by the pandemic, resulting in the postponement of elections and cancellation of government operations (Corasaniti and Saul 2020; Sfetcu 2020; Tumilty 2020). As of 20 May 2021, various forms of elections at different levels have been postponed in as many as 76 countries due to the COVID-19 pandemic, according to the International Foundation for Electoral Systems (IFES). Whereas a municipal election was postponed in Australia, parliamentary elections were also postponed in Ethiopia, while a presidential election in Somalia was suspended (IFES 2021). There were fears that President of the United States Donald Trump would use the COVID-19 emergency to declare a postponement of the 2020 US election between one and two years to take exceptional governmental powers. The responses to the COVID-19 pandemic allowed an unfettered expansion of government powers. There are concerns that governments are not likely to relinquish these unusual powers even after the pandemic has been mitigated. In the opinions of Rocco Ronchi, the COVID-19 protocol and responses prove Foucault's argument that the current power is biopolitical (Ronchi 2020). In *The Invention of Epidemic*, Giorgio Agamben contends that the pandemic measures have reinforced state mechanisms against individual freedoms (Agamben 2020a).

Many of the attempts at election postponements fell short of democratic requirements. The elections were either not immediately rescheduled or scheduled without appropriate preparation for safe and fair elections. In March 2020, President Gotabaya Rajapaksa of Sri Lanka dissolved the opposition-controlled legislature to organize early elections in April. However, the country could not hold elections within the constitutionally mandated three-month timeframe due to the health crisis. Ultimately, the election was held in August. In the five months leading up to the

August election, the president ruled without a legislature. Other elections appeared to be planned to consolidate authoritarianism. The May 2020 Burundi election proceeded with minimal or no health precautions, but international observers were compelled to quarantine. In Ethiopia and Bolivia, elections were postponed, shattering hopes that voting would bring clarity to their respective transitional situations. In Ethiopia, the reformist prime minister Abiy Ahmed assumed office in 2018 via an internal party process, with the term of Parliament set to expire in October 2020. The government decided that the Coronavirus warranted an indefinite postponement of elections, resulting in political instability and concerns of a return to authoritarian control (Repucci and Slipowitz 2020).

Between 20 per cent and 30 per cent of African countries delayed various elections because of COVID-19. There were not elections in 2020 in Libya, Nigeria, Somalia, or South Africa (International IDEA 2022; Leininger et al. 2021). Even in stable democracies, postponing elections was sometimes unavoidable, but it was imperative to promptly restore procedural normalcy to prevent political players from unconstitutionally profiting from the postponements (Leininger et al. 2021). It was manifest that a lockdown measure had the potential to impede access to health, trigger an economic recession, and even affect human rights and civil liberties (Haider et al. 2020).

COVID-19 threatened to disrupt the calendar of events for Ghana's presidential and parliamentary elections in December 2020. The COVID-19 pandemic restrictions affected the operations of Ghana's political parties (Asiseh 2020; Ghanaweb 2020b). While opposition parties were unable to organize rallies, incumbent President Nana Addo Danquah Akufo-Addo of the NPP, who was also a candidate in the election, enjoyed the advantage of incumbency. He frequently appeared on national television to deliver updates on the outbreak. The president imbued each presentation with an aura of spectacular theatrics, particularly when introducing mitigation packages. The president used the occasions of his speeches to announce subsidies on water and electricity and other packages to cushion health workers and entrepreneurs. The speeches were delivered with dramatic flair to portray sombre competence. His wax print shirts emblematically conveyed the core theme of the speeches delivered at night (K. T. Asante 2022). The motive to exploit the pandemic for political advantage was evident (Boin and Hart 2003). The government utilized the COVID-19 protocols to prove its competence and occasionally implied that NDC, the major opposition party, would have done worse. The president used the consistent broadcast updates to gain favour with voters, even though COVID-19 restrictions prevented other political parties from engaging in campaign activities during the period. The COVID-19 protocol packages became part of government campaign messages (Tsikata and Torvikey 2021). The opposition accused the government of using the crisis to engage in pork-barrel politics. Government events were not subjected to the same restrictions as other events, and it was challenging to distinguish the activities of the ruling government from its political party.

Thus, the political elites of the ruling government and the major opposition party, the National Democratic Congress, resorted to ultimately self-sabotaging measures involving 'short-term political survival strategies' that weakened the capability of the state bureaucracy (Abdulai 2021). There was what appeared to be an attempt to manipulate COVID-19 social distancing protocols to take political advantage. This was reflected in the opening of high schools to allow high school students to be camped in the school to register for targeted campaigns and voting. This decision was fiercely resisted by the main opposition party but without success.

Ghana's decision to close all the country's borders and impose restrictions on public gatherings raised concerns about the ability of the Electoral Commission (EC) to compile a new voter register in time for the 2020 elections and how the situation could affect the conduct of the 2020 general elections (K. P. Asante 2020). It was feared that the registration process might increase infections due to overcrowding at registration centres. The EC attempted, although with some difficulties,

to enforce strict COVID-19 protocols, including social distancing, wearing of face masks, and hand-washing stations, but some registration centres disregarded the protocols (Agbele and Saibu 2021).

These election issues resulting from COVID-19 were not exclusive to Ghana, and many other nations struggled with similar issues. In May 2021, the IFES reported that many African nations had rescheduled elections due to the spread of the COVID-19 virus. These countries included South Africa, Nigeria, Ethiopia, Kenya, and Cameroon (K. P. Asante 2020; IFES 2021). However, upon a tacit consensus among Civil Society Organizations and political parties, the elections went ahead as scheduled (Agbele and Saibu 2021). Ghanaians were largely against the postponement of elections because of COVID-19 and were also concerned about the constitutional implications of such postponement.

Before COVID-19, Ghana was worried about the potential of poor voter participation. In an Afrobarometer survey conducted in Ghana and published in 2019, 11 per cent of respondents stated they had no plans of voting in the 2020 elections. Consequently, obstacles to voter registration could have further dampened voter interest. The fear was that abnormally low voter participation could affect the reliability of the election, which could create additional concerns about the elections' credibility and legitimacy (Afrobarometer 2019a; K. P. Asante 2020).

The government began to ease the COVID-19 restrictions close to the elections. During the few weeks approaching the elections, the rising number of cases was no longer a matter of concern and debate (Agbele and Saibu 2021; Nikoi 2021). Contact tracing was almost abandoned in the heat of the election campaigns (Quakyi et al. 2021). Concerns about the rising rate of infections overshadowed the voting day fears of potential violence at polling stations. Fortunately, the COVID-19 protocols implemented by the EC reduced the overcrowding that accompanies polling station voting. These restrictions contributed to a smoother election, contrary to fears of a voting day spike of infection. According to Agbele and Saibu (2021), the election day infection rate was lower compared to the periods of new voter registration and campaigns.

In discussing COVID-19 and democratization, India shares many parallels with Ghana. However, India could not control the virus's spread during election periods. India escaped the first wave of the Coronavirus largely unscathed, but the second wave swept the country like a tsunami (Jain et al. 2021). A case study on the experience of elections in India during the COVID-19 pandemic, specifically between March 2020 and July 2021, provides a disaggregated account of the elections held during the period, stressing the organizational obstacles during the COVID-19 pandemic (Mahmood 2022). The elections served as vectors for COVID-19 transmission. The brazen disregard for COVID-19 guidelines shown by political parties during election campaigns reveals much about the Indian state and its institutions. The spread of COVID-19 during elections in India reinforced the notion that India is a weak-strong state (Rudolph and Rudolph 1987), able to hold elections but incapable of enforcing its COVID-19 protocols and guidelines (Mahmood 2022).

The Electoral Commission of India (ECI) could not enforce its COVID-19-related guidelines for the conduct of the elections, resulting in barefaced violations of its guidelines by political parties and voters. According to Roy and Singh (2021), the pandemic caused a reordering of public life. However, the ECI could not prevent crowded election rallies and meetings that contributed to the growth of COVID-19 cases. The Madras High Court declared the ECI solely liable for the spread of COVID-19 during the election period, labelling it the 'most irresponsible institution' in its observation of the COVID-19 outbreak during the election period (The Hindu BusinessLine 2021).

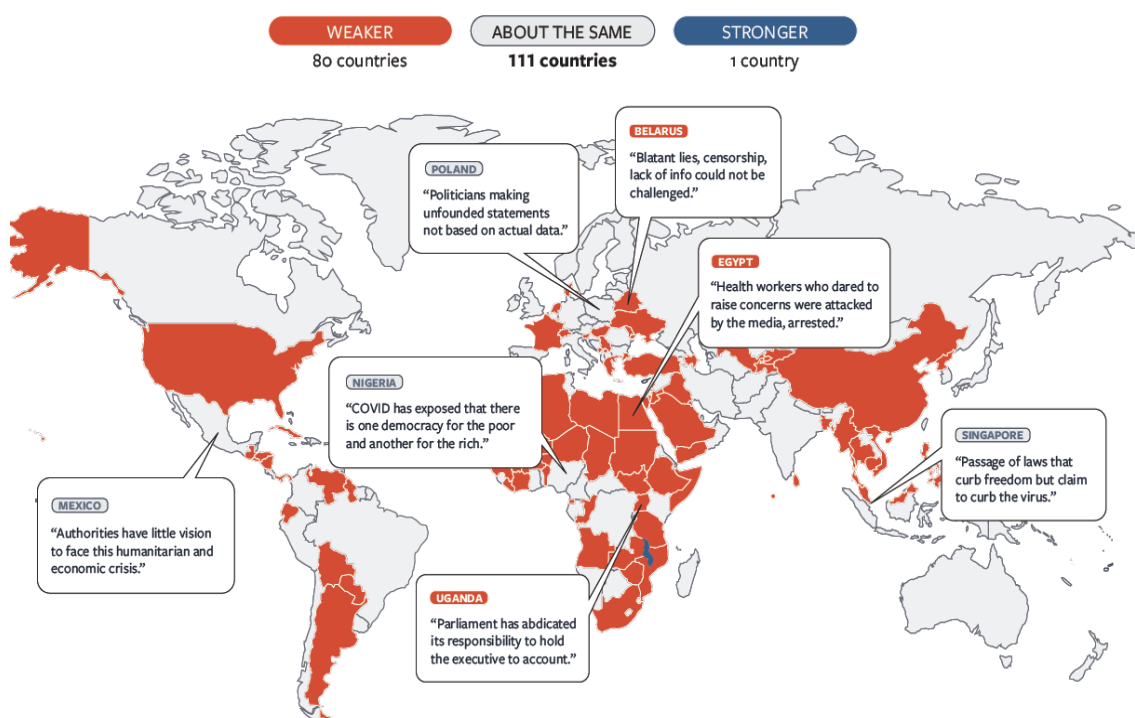
India's political life and governmental system revolve around elections (Mahmood and Ganguli 2017). Despite the pandemic, elections were held, illustrating the significance of elections in India. The elections were successful with a large voter turnout, but the success came with enormous health costs. According to official data, most states recorded increases in COVID-19 cases from March 2021 (Express Web Desk 2021). According to data, infections increased considerably in election states. On 21 April, the rate of active cases in Kerala increased by 349 per cent, from 30,228 on election day to 135,910. The number of active cases in Tamil Nadu increased by 229 per cent to 84,361 in the same period (Mahmood 2022). The number of active cases in Puducherry increased by 204 per cent to 5,404. In Assam, where triphasic elections were held (27 March, 1 April, and 6 April), infections climbed by 83 per cent from 27 March to 11 April and 344 per cent from 6 April to 20 April. After the first phase, the number of cases in West Bengal increased from 4,608 to 23,981; after the second phase, from 6,513 to 41,047; and after the third phase, from 12,780 to 58,386 (Ghosh 2021).

Indeed, the government response to the COVID-19 pandemic in Ghana has been fraught with a high perception of corruption in terms of stealing funds dedicated to COVID-19. Former President John Mahama, who was also a presidential candidate of the NDC in the 2020 elections, has, without any evidence, accused the government of using COVID-19 funds to finance its 2020 electioneering campaign. He has also demanded an independent forensic probe into the utilization of what he estimates to be over GHS25 billion in COVID-19 funding received at the height of the outbreak (Nyabor 2022).

Notwithstanding, many Ghanaians are satisfied with how the government has handled the COVID-19 pandemic (MyJoyOnline 2022). According to a survey, 87 per cent of respondents believed that the government had done well or very well in fighting the outbreak (Nugent et al. 2021). COVID-19 did not have many effects in terms of disadvantaging the opposition party affecting the human rights in Ghana compared to other African countries such as Burundi, Zambia, and Uganda, where the COVID-19 protocols completely restricted activities of the opposition parties in terms of rallies and campaigns.

According to the International Center for Not-For-Profit Law's (ICNL) COVID-19 Civic Freedom Tracker, 112 countries have declared national emergencies in response to COVID-19 or to consolidate the powers of government under the guise of COVID-19 responses. As many as 156 countries have introduced measures that affect assembly. COVID-19 response measures have affected freedom of expression in 62 countries, while 61 countries have implemented measures that affect privacy (ICNL 2022). According to data from Freedom House (Figure 2), despite the intrusiveness of the COVID-19 responses adopted and implemented, Ghana did not deteriorate its democratic gains. Democratic norms and values remained stable in Ghana (Repucci and Slipowitz 2020). The pandemic contributed to institutional recognition and legitimization of government policies, and people were generally willing to accept information from government institutions. The Partnership for Evidence-based Response to COVID-19 (PERC) conducted a survey in August 2020 in 18 countries where public support for safety measures was as high as 85 per cent. State legitimacy was high relative to government policy responses to COVID-19 (PERC 2021). In some isolated cases, Ghana's state security institutions employed minimum force to enforce the COVID-19 rules. The government relied heavily on its high legitimacy to exact voluntary compliance from the people (Levi 1989).

Figure 2: Democracy did not deteriorate in Ghana during the COVID-19 pandemic



Source: Freedom House (Repucci and Slipowitz 2020).

7 Conclusion

This study sought to appropriate and utilize the Foucauldian biopolitical framework to think with and through the torment of COVID-19 to bring various facets of the COVID-19 pandemic to light, precisely how the responses of the government of Ghana contribute to strategies of power to contain the pandemic. The paper also attempted to analyse the extent to which efforts of the Ghana government contributed to saving lives from the pandemic against all odds. Moreover, the extent to which the pandemic responses affected democratic norms and values was also critical to this research.

Implementing lockdowns, social distancing, surveillance, quarantine, and vaccination as biopolitical responses to the COVID-19 pandemic was trendy. However, Ghana's approach to these biopolitical responses was effective in governing the spread of the virus, and the responses were moderately intrusive. Compared to other places where such biopolitical responses greatly affected the rights and privacy of citizens, the COVID-19 responses were not intrusive enough to deteriorate democratic norms and values in Ghana.

This paper concludes that Ghana's successful response to COVID-19 has not resulted from some mundane factors but mainly due to the government's decisively swift, innovative, and consistent crisis management. Ghana's success story in protecting the lives of Ghanaians from the plague of COVID-19 cannot be attributed to mere providence but to state effectiveness and capacity. Notwithstanding, the Ghana government and healthcare workers should not become complacent as future pandemics may be challenging to contain.

Ghana has not learned from previous epidemics, and overreliance on reacting to events as they occur rather than taking proactive action on prevention and preparedness has meant that the

country was caught unprepared for a pandemic of this speed and scale. Indeed, the pandemic has highlighted the structural gaps in Ghana's health delivery system. The COVID-19 pandemic and its associated difficulties have compelled the government to prioritize health. Given the vulnerabilities of Ghana's health system, the government is now investing in resilience and future coping mechanisms. The president has launched 'Agenda 111' to build 111 new hospitals in regions and districts with no government hospitals and centres for disease control and prevention in response to future pandemics. Ghana is currently embarking on aggressive vaccine development and production to ensure vaccine sufficiency for health security. A National Vaccine Institute, which is being established, is expected to start commercial production by January 2024.

The President of Ghana has relatively managed to save the lives of Ghanaians from the vagaries of COVID-19. However, the pandemic continues to pose considerable hurdles to the Ghanaian economy, despite relaxing the restrictions. At a time when Ghana is still recuperating from the COVID-19 pandemic shock, the global economic shock brought on by the Russia-Ukraine crisis is simultaneously impacting the country, leaving Ghana with little space for manoeuvre. Foreign direct investment, trade and industry, energy, hospitality, and every sector has been heavily affected. Job losses and income reductions have significantly impacted households and businesses severely. Concurrently, investor fears have prompted credit rating downgrades, capital outflows, the loss of access to external markets, and increased domestic borrowing rates.

Contrary to the assurance of Ghana Beyond Aid and a promise that Ghana would not embark on an International Monetary Fund (IMF) programme, Ghana has returned to the IMF for a balance of payment support. It is puzzling how Ghana has managed to 'bring people back to life' but is struggling to do what it claimed to know how to do, 'to bring the economy back to life'. How deeply has the economy sunk, and does the government know how to regain the almost lost confidence in the economy? Time is the best sorcerer.

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