COVID-19 AND SECURITIZATION OF ITS THREATS IN SUB-SAHARAN AFRICA

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Introduction

The most recent coronavirus disease (COVID-19), caused by the SARS-CoV-2 virus, can cause severe acute respiratory complications in infected humans. As of 29 November 2021, the World Health Organization (WHO) reports over 260 million confirmed cases worldwide with over 5.2 million deaths (WHO 2021). The WHO predicts the number of confirmed cases and fatalities will continue to rise as countries relax COVID-19 containment measures and allow everyday normalcy to resume (WHO 2021). There have been more than 4.9 million COVID-19 confirmed cases in Africa since the virus broke out in December 2019, with South Africa being the worst hit with over 2.9 million cases (Johns Hopkins Coronavirus Resource Center 2021). This figure is comparatively low – over 49.3 million in the United States alone as of 29 November 2021 (WHO 2021).

The precarious state of Africa's economy, rampant poverty, and fragile healthcare systems have made the spread of COVID-19 an enormous source of concern for the continent. From an economic perspective, a recent Organi-

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zation for Economic Cooperation and Development (OECD) report contains dim predictions for Africa's economic growth due to the global pandemic based on three considerations. First, the volume of trade and foreign investments is expected to drop mid-term, with China - a significant stakeholder in bankrolling infrastructural projects in Africa - scaling down its investments. Second is the economic shock arising from a shortfall in Africa's exports due to sagging demand. Several African economies depend on exports to fund their national budget, which is bound to increase foreign borrowing and the continent's indebtedness to creditor nations. Third and relatedly, the global drop in supply due to protracted lockdowns means many African countries will struggle to feed their population or get vital imports for their manufacturing industries (OECD 2020).

From a health perspective, the WHO further painted a bleak picture of the impact of COVID-19 in Africa, projecting the virus to result in 300,000 case fatalities and push 30 million into abject poverty (WHO 2020). As of July 18, 2021, total COVID-19 deaths in Africa were less than 150,000, with more than fifty percent of these casualties from South Africa. Tunisia follows this with 11 percent and Egypt accounting for 9 percent (Johns Hopkins Coronavirus Resource Center 2021). These predictions are not outlandish considering the inadequate health care systems, general levels of poverty and malnourishment, and Africa's troubles in managing several endemic and zoonotic diseases such as malaria and the Ebola virus. The World Bank estimates that 43 percent of the over 1 billion people in SSA live below the poverty line - less than $2 per day (World Bank 2018). Not much has changed in its updated 2021 report. A report by the Economic Research Service on International Food Security Assessment for 2020-2030 estimates 921 million worldwide to be food insecure in 2020. SSA contributes more than 335 million people to this number (United States Department of Agriculture 2021). Furthermore, many African hospitals are underfunded and overcrowded and lack ventilators, COVID-19 personal protective equipment (PPEs), and other safety equipment, and there is a severe shortage of qualified healthcare practitioners (Africa Center for Disease Control 2020).

Academic literature examining the nexus between poverty and health supports the idea that countries with prevalent economic inequities, weak healthcare systems, and socially marginalized populations have a higher susceptibility to diseases (Patrick 1988; Hooper et al. 2020). In these countries, complex changes in the patterns of health and diseases are discernible from the interaction between the demographic, economic, and sociological factors in society (Laurencin & McClinton 2020). The preponderance of COVID-19 related hospitalizations, morbidities, and mortalities among African-Ameri-

cans and other racial minorities in the United States and Brazil lends credence to this (Hooper et al. 2020). There is consensus in the report published by the Brazilian Health Ministry and the United States Center for Disease Control (CDC) confirming poor living conditions, high housing density, poor access to health care, and socio-economic inequities as contributory risk factors accounting for high COVID-19 mortality among African-Americans (CDC 2020; Brazilian Health Ministry 2020).

Theoretical explanations on why Africa ought to expect disproportionately high COVID-19 deaths and hospitalizations are common. One of these theories is the African gene theory - which opines that the genetic markers in Africans increase their predisposition to chronic diseases that increase the complications and comorbidities of COVID-19 (Maraboto & Ferdinand 2020). This theory makes Africans more likely to suffer from hypertension, diabetes, and chronic kidney diseases than Caucasian counterparts (Kaufman & Hall 2003). These three diseases were identified as the primary underlying conditions predisposing to COVID-19 related deaths among African-Americans in Louisiana. Of the total case fatalities, 59 percent had hypertension, 38.1 percent diabetes, and 22.5 percent chronic kidney disease (Deslatte 2020; CDC 2020). However, there is limited pathophysiological and anthropological evidence to confirm the veracity of the genetic-based explanation for health disparities between African Americans and Caucasians.

The African hypertension hypothesis is analogous to the above. It attributes the prevalence of hypertensive disorders among Africans to high sodium retention and evolutionary history of dry conditions (Curtis 1992). Contemporary studies suggest the high hypertension rate in Africa is connected to the increased consumption of imported processed foods with plenty of added salt (Ogah and Reyner 2013; Reardon et al. 2021). Shockingly, this view has been shared by leading health authorities such as the American Heart Association (AHA) and the CDC. The CDC, for example, in a recent report, stated that "COVID-19 is lethal to African Americans because it is a pandemic jumping on top existing multiple pre-existing epidemics prevalent in the black community like hypertension, diabetes, obesity, and asthma" (CDC 2020). Likewise, the AHA believes "salt-sensitivity in Africans accounts for health disparities in hypertensive disorders" (AHA 2015). This is because hypertension is a leading cause of cardiovascular disease death in Africa - resulting in 900,000 deaths in 2016 alone (Bosu et al. 2019). Currently, Africa has the world's highest hypertension prevalence (27%) (WHO 2019). In SSA alone, 30.0 - 31.1 percent of the population are hypertensive (Bosu et al. 2019). It is noteworthy that these are often "diseases of civilization"

(Clatici et al. 2018), that may be uncommon in people who live under more traditional conditions, who live below the poverty line, and are food-deprived.

This paper proceeds as follows. In the first part, the theory of securitization and its core elements are examined. Next, we unpack the securitization narratives of COVID-19 threats in SSA. In the third part, contributory factors necessitating these framings are analysed. This is followed by an assessment of the measures taken by SSA in mitigating COVID-19. In this part, we critically parse the plausibility of COVID-19 securitization in SSA. The paper closes by suggesting a way forward for dealing with the threat posed by COVID-19 in SSA.

Theoretical framework: securitization theory

The Copenhagen School of International Relations has developed securitization theory. The theory advances an explanation on why some issues are securitized, and others are not. Securitization is defined as "an act in which an issue is deemed an existential threat to a referent object and requires emergency measures in response" (Buzan and Waever 2003, 113). The Copenhagen school argues that what is deemed a security issue is framed through the speeches and representations made by relevant political actors (Buzan 1998). This view is reflected in the definition of securitization as "a successful speech act through which an intersubjective understanding is constructed within a political community to treat something as an existential threat to a valued referent object and to enable a call for urgent and exceptional measures to deal with the threat" (Stritzle 2007, 5). Hence, nothing constitutes a security issue by itself until it is labelled as such (Waever 1995). That is, it is a rhetorical device that uses fearmongering to scare people into action by presenting risks and dangers in an objective, dispassionate way and evaluating proposed actions based on a balanced consideration of anticipated positive and negative consequences (Balzacq 2011).

The Copenhagen school recognizes two critical stages of the securitization process. The first is the speech act - which is the process of convincing an audience that an issue is an existential threat and requires urgent measures (Collins 2019). This tends to elicit a psychological response in people akin to one when faced with mortal danger. The second is the securitizing actor, the person or entity (state or non-state actor) responsible for deciding whether an issue is deemed an existential threat (Buzan et al. 1998). This is by, and large refers to the institutional side of securitization: Institutions, and

individuals within these institutions, who have to attract funding for their organizations and who stand to gain by presenting themselves as saviours (Balzacq 2011). The danger is that, first, securitization is often achieved by presenting biased or untrue information as its cataclysmic framings are only intended to elicit attention. This, however, does not translate into practical action, particularly when the securitized issue does not match reality. Also, there is an antagonism between reason and emotion, engendered by whipping up people's emotions, which often generates emotion-driven demand for actions without considering all consequences. An alternative to securitization as Charett (2009) suggests, would be actions that are sensitive and self-reflective of possible normative consequences of a situation beyond calamitous framings. This means deconstructing the institutional powers of security actors and incorporating different security possibilities that are considerate of other factors.

Applied to the purpose of this paper, securitization theory enables an understanding of speeches, reports, and publications by leading health authorities regarding the potential impact of COVID-19 in SSA as securitizing acts. In this regard, it could be argued that the way COVID-19 impacts are portrayed by experts, politicians, and the media, particularly in Africa, establishes an immanent securitization framing. This is because this rhetoric evokes fear and exigencies and beckons critical audiences and stakeholders with the exhortation that "only a willingness to act can forestall grave catastrophic consequences" (Charett 2009, 34). The idea is, if people or the targeted audience are sufficiently touched by the urgency and cataclysmic framings of an issue, it will incentivize actions (D'Arcangelis 2017). This is parallel to what Paglia Eric termed as "crisification" to explain how the rhetoric of crisis, emergencies, and calamitous situations can be used to prompt urgent actions that bypass conventional political processes (Paglia 2018). Succinctly put, security threats, whether real or imagined, would always inflame strong emotions, and prompt the need for extraordinary measures to curb them. In the next section, the emerging securitization dilemma of the global pandemic in SSA is analysed.

The securitization of COVID-19 threats in SSA

There has been a trend of securitization in international circles predicting a cataclysmic picture for COVID-19 in SSA. In a Twitter post, Melinda Gates of the Bill and Melinda Gates Foundation stated, "COVID-19 will be particularly horrible for the developing world of Africa... I see many dead

bodies in the streets of Africa like the situation in Ecuador" (Melinda on Twitter 2020). Likewise, in a press conference, the Director-General of the WHO, Dr. Tedros Adhanom, said, "Africa may be the epicenter of the Coronavirus..." (Tedros 2020). The WHO Regional Office for Africa projections as of 7 May 2020 was that 29 to 44 million African confirmed cases are anticipated in the first year of the pandemic in Africa. Of these figures, 3.6 million to 5.5 million would require hospitalization, with more than 90,000 requiring oxygen and more than 105,000 critical cases requiring ventilators (WHO 2020). This has, however, not been the case. As of 29 November 2021, there are about 8.7 million confirmed cases and 223,000 deaths of COVID-19 disease in Africa (WHO 2021). This number is significantly lower compared to India which has more than 34 million cases, as of November 2021 (WHO 2021). Evidence has shown that less urbanized parts of Africa have reported far fewer cases than very urbanized parts. A modelling study of Ghana, Kenya, and Senegal by Diop and colleagues (2020) revealed that with rural areas, COVID-19 infection may be lowered to 65%–73% (Ghana), 48%–71% (Kenya) and 61%–69% (Senegal) of the baseline infections.

Furthermore, several leading medical and health journals, such as *Lancet Journal of Infectious Diseases* and *Nature*, had several publications that applied the age-structured epidemic (ASE) model and susceptible-infected--removed (SIR) epidemic model, predicting a grim picture for COVID-19 in Africa (Sinkala et al. 2020; Wells et al. 2020; Gilbert et al. 2020). These predictions established a securitization framing of the potential threats of the global pandemic for SSA. The alarmist framings securitizing COVID-19 in Africa on the surface appear justifiable, mainly when the social, economic, and political situation in SSA is put into consideration. Presently, 70 percent of the world's poor people live in SSA. This figure is expected to increase to 87 percent by 2030 (Hamel, Tong and Hofer 2019). Africa's combined Gross Domestic Product is hardly one-third of the United States. Although the African Development Bank (AfDB) projects a 4.1 percent per capita GDP growth in Africa's economic outlook (AfDB 2020), this is looking very bleak amidst the pandemic.

Africa has more than 1.3 billion people and 54 sovereign countries, with many classified as low-income (World Bank 2021). Evidence shows that low-income countries tend to have higher median age and younger populations due to high fertility rates than high-income countries of the West. According to the World Bank (2020) data, the median age in Africa is 19.7 years, compared to 43.7 years in the European Union. This means half of the population for both continents were older or younger at these respective

ages. The age structure of a country's population is a crucial determinant of economic growth, literacy levels, labour force, and healthcare services.

Earlier predictions of COVID-19 impact in Africa were expected to lead to severe hospitalization levels due to the higher risk of spread envisaged in low-income countries. As Simon (2020, 7) posits, "In low and lower-middle-income countries, they often constitute the urban majority inhabiting areas of sub-standard and irregular housing, and are exposed to absolute poverty, which increases their susceptibility to highly contagious diseases". One prediction is that case numbers and fatalities are declining in the rich countries with first access to vaccines, but cases in Africa will rise when highly contagious virus variants spread there while most people are still unvaccinated (Ghisolfi et al. 2020). Other predictions based on local and regional patterns foresee the concentration of COVID-19 in some parts of SSA as evidence of a third wave that would increase active cases number and casualty figures in coming years (Mbow et al. 2020). However, there is still no empirical scientific evidence to verify these predictions. As Simon and colleagues note,

> [...] concerns about higher morbidity and mortality rates among Black, Asian and Minority Ethnic (BAME) groups in the UK and Europe, African-Americans and BIPOCs (Black, Indigenous, People of Colour) in the USA and other minorities and marginalized groups elsewhere were well-founded. However, rather than resulting from any genetic predisposition, the sources of vulnerability were largely contextual, environmental, social, and behavioral (Simon et al. 2020, 5).

In other words, these predictions foresaw minorities and marginalized groups as high-risk groups due to prevalent social, economic, and environmental, and health inequities, which purportedly increased Africa's susceptibilities. Many African countries had poor waste and sanitation systems, lacked adequate public open spaces in urban settlements, and had more inadequate amenities and public utilities than the West. While these predictions were based on the prevalent structural fault lines in the continent, contrary studies suggest the current age structure and favourable weather in Africa as possible explanations for the low confirmed cases and casualties from COVID-19 (Njenga et al. 2020). Though this may change in the coming years with the emergence of new variants of COVID-19, it is unlikely, based on the current pattern, that morbidity and mortality figures from the disease will be proportionately higher in Africa than the global North. Furthermore, the lack of exhaustive scientific evidence on why COVID-19 casualty rates are higher in Tunisia, South Africa, and Egypt and not in more populated

cities of Africa such as Lagos, Nigeria negates the nexus linking the level of urbanization to COVID-19 infections.

Several factors have been emphasized in the securitization framing of COVID-19 in SSA. Some are examined in more detail below.

The practicability of COVID-19 mitigation strategies

Public policy measures were implemented in several countries in SSA to prevent the spread of COVID-19 within the local population. These included lockdowns, curfews, closing markets and churches, and limiting public gatherings to 1-10 persons. Most of these measures were adapted from other countries also containing the virus spread. However, these measures raise questions about the feasibility of their implementation in SSA. First, these measures exacerbate pre-existing socio-economic inequities due to the reliance of many Africans on daily wages. Secondly, poor housing conditions in SSA mean many people live in poorly lit and too closely spaced make-shift houses, which makes the idea of working remotely or maintaining social distancing utopian (Nyenyezi 2020).

Third, lockdown measures in many parts of SSA were rarely implemented with social safety nets for feeding and sustenance comparable to high-income countries. Though several governments implemented palliative measures such as free online education for school students, food packages, and cash disbursements, the impracticability of sustained lockdowns led to their halt. This made some governments such as Ghana, Burkina Faso, Kenya, Liberia, Tanzania, Nigeria, and Ethiopia impose limited or adapted lockdown measures instead (Wallace et al. 2020). Furthermore, issues of reliable power supply, internet affordability, and speed made online education unworkable. In high-income countries such as Italy, Spain, China, and New Zealand, these measures effectively slowed down the COVID-19 curve. Obstacles to implementing the same measures in SSA contribute to the securitization framing of the pandemic's purported threats in the region.

Exacerbated inequalities

A significant contributor to the securitization predictions for COVID-19 in SSA is the preponderance of exacerbated inequalities that have persisted since colonial times. This casts a cloak of uncertainty in assessing the effectiveness of interventions geared to mitigate the impact of the pandemic and further perpetuates the securitization framing of its purported threats. Studies have determined that a deeply entrenched post-colonial pattern of

control and direct access to the needed resources are monopolized mainly by political elites and disenfranchises the poor (Palermo 2020; Nyenyezi 2020). This points to the close connection between leadership and the perpetuation of socially determined vulnerabilities and other health inequities related to COVID-19 (Bertram et al. 2020). Furthermore, the incidence of COVID-19 in Africa has shown the mismatch between expert predictions and ongoing realities. Some of these predictions were based on economic, social, and health inequities in the continent, which were projected to increase health crisis, hospitalizations, poverty levels, and ultimately casualties from the disease. However, some of these assumptions have been wrong as they failed to consider other dynamics such as age, urbanization, and other markers that would prevent account for the epidemiology of the disease. For instance, there have been less than 2200 COVID-19 deaths in Lagos State, Nigeria, which has a population of over 15 million people and a very crowded urban settlement compared to Cape Town, which has been one of the epicenters of the COVID-19 outbreak in South Africa (Statisca 2021).

There is an opportunity to encourage indigenized approaches for evaluating COVID-19 in Africa. This means allowing African-based researchers more space to contribute to the research and provide their input into policies for the region. This is premised on the notion that foreign initiatives mainly from the West do not consider local peculiarities and socio-cultural contexts. Experts and researchers based in Africa can contribute more robust social and scientific understandings of the ideas, conditions, and social relations in the places where COVID-19 control measures are implemented. This further implies recognizing and funding local expertise and knowledge and changing the institutional arrangements that lead African researchers to experience unearned disadvantage (Plamondon and Bisung 2019). Ideally, African researchers could get more funding if they present COVID-19 as a terrible threat that only scientists can vanquish. That is what scientists do elsewhere in the world, and that is what securitization is all about (Ilesanmi et al. 2020). The point here is that the securitization of a particular threat based on perceived inequalities without recognizing local contexts may not bring about holistic intervention measures.

Logistical factors

The logistics of coordinating COVID-19 response strategies have been viewed as contributory factors projecting the securitization narrative of its threats. In some countries, including Kenya, Ghana, Uganda, and Cameroon, the centralized coordination of the national COVID-19 response was

thought to contribute to challenges with procurement and distribution of already available supplies (Palermo 2020). In addition, the dearth of mental health support for healthcare workers who work in proximity of COVID-19 patients has also been identified as a source of challenge towards ensuring effective preventive measures (Osseni 2020). In countries like Tanzania, Nigeria, and Cameroun, reports on the shortage of PPEs, isolation equipment, treatment centers, testing centers, oxygen tanks, ventilators, and infectious disease specialists raised concerns predicting a significant spate of COVID-19 hospitalizations and deaths (Bertram et al. 2020).

Public perception

Public perception plays a crucial role in the transmission of COVID-19. This is because people's beliefs amplify mistrust or confer legitimacy to government efforts. A study published by The Lancet Global Health reveals a direct correlation between individual perception of the COVID-19 virus and willingness to comply with government directives (The Lancet Global Health 2020). In SSA, previous experiences with the government's ability to manage earlier health crises, such as Ebola in the Democratic Republic of Congo, Liberia, and Guinea and Lassa Fever in Nigeria, have caused mistrust and fostered securitization of COVID-19. The ramification of this can impact adversely on government's measures at containing transmission due to mistrust, mainly when people doubt the quality of healthcare and the genuineness of government intervention strategy.

The indefensibility of securitization in SSA

Despite its utility in galvanizing needed action for an issue framed as an existential threat, securitization does not always translate to effective measures to address this threat (Weaver 1993; Kelle 2007). This draws a parallel to climate change rhetoric, which has also been construed as an essential threat to emotion without providing a practical guide to effective action (Okpaleke and Abraham-Dukuma 2020). Hence, framing COVID-19 as an existential threat with a cataclysmic impact for Africa may not catalyse needed actions to address the socio-economic and health inequities that increase the spread of COVID-19. Three factors may account for this. First, rather than prompt needed actions, securitization of COVID-19 may elicit obverse and mundane reactions within domestic audiences. This is because the portrayal of the disease as catastrophic may come across as premeditated and strategic by politicians to arouse action,

raising initial skepticism or outright rejection. For instance, in countries where scaremongering during an election is commonplace, people are likely to react less differently to a securitized referent (Paglia 2018).

Second, securitization is often premised on "what might happen" rather than "what is happening". Hence, raising uncertainty over the materialization of its threats and how the projected grim visions would resonate with key audiences. This, however, does not elicit needed actions as people have learned to trust their eyes more than the words of their politicians and the media. This is because securitizing an issue is often enshrouded in uncertainty due to the burden of proof required to legitimize framings. As with COVID-19, those leading health experts may consider its pathology sufficiently proven; anticipated catastrophes' sources are not easily predictable. The more crucial point is that people cannot evaluate the sources of information about purported existential threats. They have to trust the sources of the information, which they often do not do. For example, as WHO data on COVID-19 related hospitalizations, confirmed cases, and fatalities have shown, Africa has reported far fewer deaths than other world regions (WHO 2021).

According to WHO Coronavirus dashboard, as of 6 June 2021, there were less than 1.4 million confirmed cases of COVID-19 in Africa; this figure was about the same number of fatalities in the United States, India, and Brazil. Comparatively, the COVID-19 deaths in the United States (over 800,000 as at November 2021) are higher than the total in Africa (223,000 of the same period) (WHO 2021). The incidence of the virus in Africa so far has defied most predictions (see table 1 below). The current estimated fatality rate of 0.66 percent of confirmed cases that has died is far lower than the projected fatality rate of 3.1 percent (Africa CDC 2020). This makes some of the fatalistic predictions for SSA overly pessimistic, particularly as it failed to recognize the deterministic effect of local realities and socio-cultural peculiarities in affecting the spread of the virus.

Table 1: Continental comparisons in COVID-19 active cases and deaths from July 2020-2021

		COVID-19 in July 2020		**COVID-19 in July 2021**	
	Population	Active Cases	No of Deaths	Active Cases	No of Deaths
Africa	1.3 billion	874,000	18,498	7 million	177,000
Europe	748 million	3.2 million	205,000	53 million	1.1 million

		COVID-19 in July 2020		COVID-19 in July 2021	
	Population	Active Cases	No of Deaths	Active Cases	No of Deaths
North America	371 million	13million	380,000	44 million	958,000
World	7.9 billion	67 million	1.2 million	206 million	4.35 million

Source: Data compiled from World Health Organization, Worldometer, and Johns Hopkins Coronavirus Resource Center.

Recent medical research offers two hypotheses that may explain Africa's low death toll. The first postulates an evolutionary adaptation to the scourge of Malaria in Africa that may have been selected for improved immunity to COVID-19 as a side effect; the second proposes malaria chemoprophylaxis with hydroxychloroquine, and similar drugs may lower mortality and hospitalizations (Kearney 2020). Though research investigating the possible immunomodulating effect of antimalarial medications on Africans against COVID-19 is still ongoing, the limited impact of the virus in the region has so far negated the securitization framing of its threat in the SSA region. There is, however, a caveat. It is still too early to tell if COVID-19 would worsen or recede in the coming months in SSA, especially considering the emergence of more contagious virus variants. Most modeling of the virus in Africa predicts a surge before it flattens out sometime in 2021 (Sinkala et al. 2020; Wells et al. 2020; Yancy 2020; Gilbert 2020). Also, contra studies posit that limited testing, poor data management, and discrepancies in reporting protocols may lead to an underestimation of deaths in Africa (Gilbert et al. 2020). Furthermore, there is still the risk that a new mutated variant of the virus would lead to a spike in hospitalizations, reported cases and deaths in SSA due to COVID-19. In the next section, we examine efforts made by governments in Africa and the African Center for Disease Control in mitigating the impact of COVID-19 in SSA and, as a consequence, reversed the securitization framing of its threats for the region.

Africa's response to the pandemic

The Ebola health crisis of 2014-2015 in West Africa nearly resulted in a global pandemic save for the efforts of international and national government and donor agencies and partners that worked with African leaders to control the threat. COVID-19 prevention measures in SSA started with countries

containing threats by controlling their borders. Ivory Coast was the first to implement enhanced surveillance and screening protocols for all passengers with a travel history to China. On 2 January 2020, more than a month before the first index case was reported in Egypt on 14 February 2020 (Muagerita et al. 2020). Most European countries only started closing their borders by March 2020. According to the African Center for Disease Control (Africa CDC), most African countries adopted both containment and mitigation strategies to stem the surge of the virus. These included: the imposition of travel bans on European and Asian countries, instituting mandatory quarantine, setting up isolation facilities, temporary closing of land borders and for incoming flights, restricting public movements, announcing nationwide lockdown measures, and restricting public gatherings (Africa CDC 2020). As of July 2020, more than 50 countries in Africa had closed their borders. These measures arguably played a valuable role in early efforts that prevented the surge of the virus in the region. As of 27 September 2020, the number of active cases in SSA was still under 250,000 (precisely, 1,148,548 recovered cases) (Africa CDC 2020).

From a technical standpoint, the Africa CDC has also played a crucial role in reversing the securitization framing of the virus on the continent. The agency in charge of the continent's health security and disease prevention matters held weekly coordination meetings with national, regional, and collaborating health ministries and agencies. As of 27 January 2020, it activated its Emergency Operations Centre that published weekly reports on the transmission and pathology of the virus (Africa CDC 2020). This ensured that regular, up-to-date, and verifiable information on alerts and surveillance reports were provided to member states in real-time (Nebe & Jalloh 2020).

Furthermore, the late reporting of COVID-19 cases in SSA compared to other regions meant Africa was afforded ample time to prepare an effective mitigation response. This was reflected in the African Joint Continental Strategy for COVID-19 - which was unanimously adopted in February 2020 by Heads of States and Government of member states and reflected Africa's united front to forging an efficacious pandemic response strategy. The continental strategy, among other things, comprised partnerships with health agencies at the national and regional levels dedicated to disease control (Cornish 2020). To ensure its effective implementation, the strategy received funding from several donors, including the Bill and Melinda Gates Foundation, Jack Ma Foundation, the Ethiopian government, European Union, the United States government, and the African Union COVID-19 Response Fund. These funds were committed to strengthening emergency operations, ensuring effective surveillance, contact tracing, setting up quarantine centers, and providing needed medical supplies and healthcare and PPE (Muagerita et al. 2020).

The African Task Force for Coronavirus, which was saddled with the sole responsibility of implementing the continental strategy, was also set up. Its technical function encompassed ensuring the working of the respective working groups, increasing surveillance at borders, facilitating risk control and communication, and supporting states in the national implementation of lockdowns and preparedness against the public-health COVID-19 crisis.

It is however imperative to determine the efficacy of the measures adopted in SSA to prevent the securitization framing of the virus in the region. First, from the prevention side, the region's Partnership to Accelerate COVID-19 Testing (the 'PACT initiative') ensured that testing, contact tracing, isolation, and treatment of cases were put in place in all member states. The PACT's goal was to ensure a fast-track testing of 10 million Africans within six months. This also engendered research on novel diagnostic testing kits (Thebault 2020). For example, the Pasteur Institute in Dakar, Senegal, has been undertaking clinical trials of its virus diagnostic Polymerase Chain Reaction (PCR) test kits, which boast of producing results faster than the kits currently used in the West.

Second, the technical know-how from dealing with previous disease outbreaks and emergencies such as Lassa Fever, Ebola virus, Measles, Polio, and Human Immunodeficiency Virus (HIV) meant Africa had a repository of tools and knowledge for dealing with health emergencies. Arguably, this helped facilitate the mobilization of health resources in dealing with the virus in Africa. Third, allowing home-grown initiatives such as local face masks, face shields, hand sanitizers, ventilators, support triage, contact tracing applications, and other health products helped boost the capacity to deal with the virus and prevent shortages of some of these items (Osseni 2020).

In sum, Africa's response demonstrated the futility of the securitization framing of the COVID-19 threats for the region. It can be argued that the securitization of COVID-19 was the reason Africa responded so early and successfully. First, measures were already taken before this was elevated to an existential threat by political rhetoric and the media, and everyone panicked. Rather than elevating the pandemic to an existential threat, African countries treated it as yet another health challenge, like Lassa, Ebola, and HIV, met pragmatically with appropriate measures.

It is worth emphasizing that efforts had already been underway in SSA countries as far back as January 2020, before the rhetoric about the catastrophic impact of the pandemic was fully formed. However, one can argue that COVID-19 threats were generally securitized globally by leading health authorities such as the WHO and the CDC, anticipating that Africa

would have been even worse off based on the impact of the virus in Europe, Asia, and North America. As the preceding has shown, SSA's preparedness, though not wholly perfect, helped reverse the securitization logic of the purported threats of the virus.

Strengthening Africa's COVID-19 response

There is a need to strengthen the ongoing efforts in SSA to stem the tide of COVID-19 in the region. This entails improving in the short term the availability of PPEs, opening well-equipped and staffed laboratories, quarantine, and isolation centers in all countries and municipalities. Critical medical equipment such as ventilators, triage, oxygen, and beds should also be provided to treat COVID-19 patients. This is still a burgeoning concern in many countries in SSA despite the high recovery rate and low case fatalities. In addition, relevant healthcare training needs to be provided, including mental health and psychosocial support for healthcare and essential workers. Furthermore, due to limited resources, vaccinations should be focused on health personnel and risk groups, especially old and chronically ill people. There is near certainty of possibly achieving 100 percent vaccination in SSA everyone before spreading the more contagious new virus variants, so a pragmatic approach is needed where prevention is focused on those who most need it.

Risk communication strategies that consider local social and cultural values need to be embraced in citizen engagement. Apart from winning the hearts and minds of the people to embrace government mitigation strategies for the virus, it builds trust and allows for better integration in dealing with the pandemic. Community outreach will engage vulnerable populations, encourage health-seeking behaviour, and change preconceived beliefs about the virus (Verity 2020). Further barriers to access to COVID-19 care services in remote areas can be alleviated with dedicated mobile treatment units, especially in those hard-to-reach areas and communities that the virus has reached despite their remoteness. Osseni (2020, 8) notes, 'these supports must be informed by a transparent approach that builds trust and recognizes local know-how and existing health system capacity…'.

In the medium-term, African governments and stakeholders need to support and partner home-grown or African-led initiatives. This allows for the indigenization of global health and COVID-19 response. It allows for the expansion of capacity at the domestic and regional level to provide the technical know-how, skillset, resources, and region-specific knowledge

that would drive research and formulate policies that are African-led and African-focused. This has long-term benefits for the health sector and future public health response planning. From an economic perspective, policy measures need to address the extreme socio-economic health inequalities in most countries in SSA. This entails making policies that reduce Africa's mounting debts, structural dependency, and over-reliance on external financial flows to a more competitive, diversified, and effective service sector-driven economy that prioritizes employment and human capacity development. This way, Africa can fight the pandemic without aggravating existing socio-economic inequalities, debt burden, unemployment, etc. One of the ways to do this is to effectively implement the African Continental Free Trade Area (AfCFTA), which will strengthen the region's value chains, mitigate against vulnerabilities to economic shocks, allow for better technology and skill transfer and ensure the resilience of African economies to changes in the global market. This, in the long term, creates the needed resources to fight threats like COVID-19 in the continent.

There is also the need to implement the goals of Africa's continental strategy. The United Nations Economic Commission for Africa estimates that every lockdown period set back Africa's GDP by 2.5 percent. The implication is that African economies may continue to suffer and take a long time to recover post-COVID. This will also mean that socio-economic inequities may worsen as governments find it increasingly challenging to support social welfare programmes and invest in capital expenditures. By sticking to the continental strategy, Africa stands a chance. The strategy works in synergy with international funding agencies and critical development banks to ensure that necessary palliatives are put in place to cushion social inequalities. Also, pooled procurement mechanisms will contribute to safeguarding equitable access to new COVID-19 diagnostics, therapeutics, and vaccines in record time and at scale. As Wallace et al. (2020, 6) note:

> [...] while these COVID-19 mitigation funds will undoubtedly help, it is crucial that African countries come together as one and make their voices heard to inform the choice of priorities to ensure maximum impact. Failure to cooperate globally and act decisively in Africa will translate into the sustained transmission and pose a risk to all (Wallace et al. 2020, 6).

However, while it may appear that African bureaucrats and leaders have so far exceeded expectations, there are still future challenges ahead, especially with the new variants of the COVID-19 virus and the economic impossibility to continue to impose lockdown measures and closing borders forever.

Conclusion

In this paper, the issue of securitization related to the threats of COVID-19 in SSA has been examined. The motivation of the study was based on the reports, speech acts, and publications that predicted a cataclysmic impact of the global pandemic on Africa due to its weak healthcare systems, prevailing socio-economic inequities, and poverty dynamics. Deductively, the preceding arguments portray a massive negative impact for COVID-19 in Africa. As this paper argues, this has engendered over-securitization of its purported threats. The essence of securitization is to sell or label COVID-19 as top security and humanitarian concern to arouse needed national and international action to this existential threat. However, as our assessment shows, the framing is overly exaggerated and pessimistic about Africa's pandemic mitigation strategies. It underplays the role of Africa's age structure, urbanization level, and how home-grown initiatives have been used to stem the tide of COVID-19 in SSA, even if most of these measures are adapted from overseas. There are key findings from our study.

First, implementing the Africa CDC continental strategy to cushion the effect of COVID-19 in the region unexpectedly demonstrated good preparedness for a pandemic. This shows that the securitization framing is not justified. The pandemic should instead be treated as a practical challenge and not as an existential threat. The relative success of SSA, compared to Western countries, for instance, showed that the securitization rhetoric that is standard in the West did not lead to effective containment measures there and that a more pragmatic, down-to-earth approach like the one adopted in most of Africa is needed. This is not unconnected to the politics in the West that has morphed more into an ideology-driven lifestyle politics that is not outcome-oriented but appeals more to people's emotions. This underscored the pragmatic versus the emotional nature of the response in the West different from the realities that were obtainable in Africa. The angry mass demonstrations against perfectly reasonable COVID-19 restrictions in many parts of Europe and the UK highlighted this and further contributed to the spread of the disease by bringing big crowds together. This emphasizes that politicians and the media fearmongering over COVID-19 threats is bound to produce a widespread backlash; therefore, measures to protect the risk groups may be sufficient.

Second, the logic behind the securitization of COVID-19 in SSA is faulty, considering that despite the predictions by leading health authorities, the continent still has a comparatively low case fatality ratio and a total

number of cases than other regions of the world. This is because, with the youthful age structure of Africa populations compared to the West, COVID-19 has not posed a severe threat to SSA, besides some of the home-grown measures instituted by bureaucrats.

Third, most of the COVID-19 predictions for Africa are overly exaggerated and pessimistic of the region's capacity to self-help and devise home-grown measures to mitigate the spread of the disease. Moreover, while it can be argued that the infection rate in SSA appears lower than it is because of underreporting, other measures, such as relatively less urbanization than in most other parts of the world, certainly plays a role and should be put into consideration.

Fourthly, though there exist some caveats regarding the progression of COVID-19 in SSA, current data on the morbidity and mortality of the virus do not justify apocalyptic visions of its impact. If at all, they do not consider the deterministic effect of local realities and socio-cultural context in altering the spread of the virus. There is saliency to strengthen local and home-grown measures in ensuring efforts to prevent the further spread of the virus. This ideally means a greater need for synergistic collaborations with health and partner agencies at all levels in flattening the curve, making alarming projections and rampant securitization of the problem an inadequate response.

A holistic response agenda to COVID-19 by African leaders would no doubt boost the continents' chances of preventing a full blown and uncontrollable health crisis in SSA. While securitization may engender apocalyptic framing of purported threats, SSA leaders should see these framings as a call to improve health care systems, social housing, social infrastructures, and vaccine research programmes. It is too early in the day to scientifically determine what the long term of COVID-19 would be considering the rise of new mutated strains. What remains key is ensuring that proper mechanisms are put in place to safeguard SSA from the debilitating impact of the pandemic.

References

American Heart Association. 2015. "Social Determinants of Risks and Outcomes for Cardiovascular Disease: A Scientific Statement from the American Heart Association." *Circulation* 132: 873-898. doi:10.1161/CIR.0000000000000228. Accessed June 6, 2021.

Balzacq, Thierry (Ed.). 2011. *Securitization theory. How Security Problems Emerge and Dissolve*. London: Peace Research Institute Oslo (PRIO) - New Security Studies.

Brazil, Ministry of Health. 2020. "Official Gazette Information Related to Coronavirus." Accessed June 6, 2021. https://coronavirus.saude.gov.br/.

Bosu, William Kofi, Justice Moses Kwaku Aheto, Eugenio Zucchelli, and Siobhan Theresa Reilly. 2019. "Determinants of Systemic Hypertension in Older Adults in Africa: A Systematic Review." *BMC cardiovascular disorders* 19, no. 173: 1-24. https://doi.org/10.1186/s12872-019-1147-7.

Bosu, William Kofi, Siobhan Theresa Reilly, Justice Moses Kwaku Aheto, and Eugenio Zucchelli, E. 2019. "Hypertension in Older Adults in Africa: A Systematic Review and Meta-Analysis." *PloS one* 14. no. 4: e0214934. https://doi.org/10.1371/journal.pone.0214934.

Centre for Disease Control (CDC). 2020. "Severe Outcomes among Patients with Coronavirus Disease 2019 (COVID-19) – United States, February 12–March 16, 2020." *MMWR Morbidity Mortality Weekly Report* 69, no. 12: 343-346.

Charrett, Catherine. 2009. "A Critical Application of Securitization Theory: Overcoming the Normative Dilemma of Writing Security." *International Catalan Institute for Peace, Working Paper* (2009/7).

Clatici, Victor Gabriel, Cristiana Voicu, Catalina Voaides, Anca Roseanu, Madalina Icriverzi, and Stefana Jurcoane. 2018. "Diseases of Civilization–Cancer, Diabetes, Obesity and Acne–the Implication of Milk, IGF-1 and mTORC1." *Mædica* 13, no. 4: 273-281. doi: 10.26574/maedica.2018.13.4.273.

Curtin, P. D. 1992. "The Slavery Hypothesis for Hypertension among African Americans: The Historical Evidence." *American Journal of Public Health* 82. no. 12: 1681-1686. doi: 10.2105/ajph.82.12.1681.

D'Arcangelis, Gwen. 2017. "Reframing the 'Securitization of Public Health: A Critical Race Perspective on Post-9/11 Bioterrorism Preparedness in the United States." *Critical Public Health* 27. no. 2: 275-284. https://doi.org/10.1080/09581596.2016.1209299.

Deslatte, Melinda. 2020. "Louisiana Data: Virus Hits Blacks, People with Hypertension." *US News World Report.* April 7, 2020. Accessed June 6, 2021. https://www.usnews.com/news/best-states/louisiana/articles/2020-04-07/louisiana-data-virus-hits-blacks-people-with-hypertension.

Ghisolfi, Selene, Ingvild Almås, Justin C. Sandefur, Tillman von Carnap, Jesse Heitner, and Tessa Bold. 2020. "Predicted COVID-19 Fatality Rates based on Age, Sex, Comorbidities and Health System Capacity." *BMJ global health* 5, no. 9. e003094. http://dx.doi.org/10.1136/bmjgh-2020-003094.

Gilbert, Marius, Giulia Pullano, Francesco Pinotti, Eugenio Valdano, Chiara Poletto, Pierre-Yves Boëlle, and Bernardo Gutierrez. 2020. "Preparedness and Vulnerability of African Countries against Importations of COVID-19: A Modelling Study." *The Lancet* 395 (10227): 871-877. https://doi.org/10.1016/S0140-6736(20)30411-6.

Hamel, Kristofer, Baldwin Tong, and Martin Hofer. "Poverty is Falling in Africa but not Fast Enough." *Brookings*, March 28, 2019. Accessed June 6, 2021. https://www.brookings.edu/blog/future-development/2019/03/28/poverty-in-africa-is-nowfalling-but-not-fast-enough/.

Hooper, Monica Webb, Anna María Nápoles, and Eliseo J. Pérez-Stable. 2020. "COVID-19 and Racial/Ethnic Disparities." *Jama* 323. no. 24: 2466-2467. doi:10.1001/jama.2020.8598.

Ilesanmi, Olayinka Stephen, Ayomide Esther Bello, and Aanuoluwapo Adeyimika Afolabi. 2020. "COVID-19 Pandemic Response Fatigue in Africa: Causes, Consequences, and Counter-Measures." *The Pan African Medical Journal* 37. doi: 10.11604/pamj.supp.2020.37.37.26742.

Johns Hopkins Coronavirus Resource Centre. 2021. "COVID-19 Dashboard by the Centre for Systems Science and Engineering at the Johns Hopkins University and Medicine." *John Hopkins University & Medicine*. Accessed June 6, 2021. https://coronavirus.jhu.edu/map.html.

Kaufman, Jay S., and Susan A. Hall. 2003. "The Slavery Hypertension Hypothesis: Dissemination and Appeal of a Modern Race Theory." *Epidemiology* 14, no. 1: 111-118.

Kearney, John. 2020. "Chloroquine as a Potential Treatment and Prevention Measure for the 2019 Novel Coronavirus: A Review." *Preprints*, 2020030275. doi: 10.20944/preprints202003.0275.v1.

Kelle, Alexander. 2007. "Securitization of International Public Health: Implications for Global Health Governance and the Biological Weapons Prohibition Regime." *Global Governance: A Review of Multilateralism and International Organizations* 13, no. 2: 217-235.

Laurencin, Cato T., and Aneesah McClinton. 2020. "The COVID-19 Pandemic: A Call to Action to Identify and address Racial and Ethnic Disparities." *Journal of racial and ethnic health disparities* 7. no. 3: 398-402. doi: 10.1007/s40615-020-00756-0.

Makoni, Munyaradzi. 2020. "Africa Prepares for Coronavirus." *The Lancet* 395 (10223): 483. doi: 10.1016/S0140-6736(20)30355-X.

Maraboto, Carola, and Keith C. Ferdinand 2020. "Update on hypertension in African-Americans." *Progress in Cardiovascular Diseases* 63, no. 1: 33-39. doi: 10.1016/j.pcad.2019.12.002.

Mbow, Moustapha, Bertrand Lell, Simon P. Jochems, Badara Cisse, Souleymane Mboup, Benjamin G. Dewals, ... and Maria Yazdanbakhsh. 2020. "COVID-19 in Africa: Dampening the Storm?" *Science* 369 (6504): 624-626. doi: 10.1126/science.abd3902.

Njenga, M. Kariuki, Jeanette Dawa, Mark Nanyingi, John Gachohi, Isaac Ngere, Michael Letko, ... and Eric Osoro. 2020. "Why is there Low Morbidity and Mortality of COVID-19 in Africa?" *The American Journal of Tropical Medicine and Hygiene* 103, no. 2: 564-569. https://doi.org/10.4269/ajtmh.20-0474.

Nyenyezi Bisoka, Aymar. 2020. "Disturbing the Aesthetics of Power: Why COVID-19 is not an "Event" for Fieldwork-Based Social Scientists." (No. UCL-Université Catholique de Louvain).

Okpaleke, Francis N., and Magnus Abraham-Dukuma. 2020. "Dynamics of Resource Governance, Climate Change, and Security." *Journal of Strategic Security* 13, no. 4: 123-140. https://doi.org/10.5038/1944-0472.13.4.1824.

Osseni, Issideen Ayinla. 2020. "COVID-19 Pandemic in Sub-Saharan Africa: Preparedness, Response, and Hidden Potentials". *Tropical medicine and health* 48, no. 1: 1-3. https://doi.org/10.1186/s41182-020-00240-9.

Ogah, Okechukwu S., and Brian Rayner. 2013. "Recent Advances in Hypertension in Sub-Saharan Africa." *Heart* 99, no. 19: 1390-1397. http://dx.doi.org/10.1136/heartjnl-2012-303227.

Paglia, Eric. 2018. "The Socio-Scientific Construction of Global Climate Crisis." *Geopolitics* 23. no. 1: 96-123. https://doi.org/10.1080/14650045.2017.1328407.

Plamondon, Katrina M., and Elijah Bisung. 2019. "The CCGHR Principles for Global Health Research: Centering Equity in Research, Knowledge Translation, and Practice." *Social Science & Medicine* 239: 112530. doi: 10.1016/j.socscimed.2019.112530.

Palmer, Colin A. 2000. "Defining and Studying the Modern African Diaspora." *The Journal of Negro History* 85 (1-2): 27-32. https://doi.org/10.1086/JNHv85n1-2p27.

Patrick, Donald. L., Jane Stein, Miquel Porta, Carol Q. Porter, and Thomas C. Ricketts. 1988. "Poverty, Health Services, and Health Status in Rural America." *The Milbank Quarterly* 66, no. 1: 105-136.

Piguillem, Facundo, and Liyan Shi. 2020. "Optimal COVID-19 Quarantine and Testing Policies." *Einaudi Institute for Economics and Finance (EIEF) Working Paper*. https://econpapers.repec.org/paper/eiewpaper/2004.htm.

Reardon, Thomas, David Tschirley, Lenis Saweda O. Liverpool-Tasie, Titus Awokuse, Jessica Fanzo, Bart Minten, ... and Barry M. Popkin. 2021. "The Processed Food Revolution in African Food Systems and the Double Burden of Malnutrition." *Global food security* 28: 100466. https://doi.org/10.1016/j.gfs.2020.100466.

Simon, David, Angeles Arano, Mariana Cammisa, Beth Perry, Sara Pettersson, Jan Riise, ... and Warren Smit. 2021. "Cities Coping with COVID-19: Comparative Perspectives." *City*: 1-42. https://doi.org/10.1080/13604813.2021.1894012.

Sinkala, Musalula, Panji Nkhoma, Mildred Zulu, Doris Kafita, Rabecca Tembo, and Victor Daka. 2020. "The COVID-19 Pandemic in Africa: Predictions using the SIR Model Indicate the Cases are Falling." *medRxiv*. doi: 10.26502/fjhs.038.

Shereen, Muhammad Adnan, Suliman Khan, Abeer Kazmi, Nadia Bashir, and Rabeea Siddique. 2020. "COVID-19 Infection: Origin, Transmission, and Characteristics of Human Coronaviruses." *Journal of Advanced Research*. DOI: 10.1016/j.jare.2020.03.005.

Stritzel, Holger. 2007. "Towards a Theory of Securitization: Copenhagen and Beyond." *European Journal of International Relations* 13, no. 3: 357-383. https://doi.org/10.1177/1354066107080128.

Thebault, Reis, Andrew Ba Tran, and Vanessa Williams. 2020. "The Coronavirus is Infecting and Killing Black Americans at an Alarmingly High Rate." *Washington Post*, April 7, 2020. https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killingblack-americans-an-alarmingly-high-rate-post-analysis-shows/. Accessed June 6, 2021.

Wæver, Ole. 1993. *Securitization and Desecuritization*. Copenhagen: Centre for Peace and Conflict Research.

Walker, Patrick, Charles Whittaker, Oliver Watson, Marc Baguelin, Kylie Ainslie, Sangeeta Bhatia, ... and Zulma Cucunuba Perez. 2020. "Report-12: The Global Impact of COVID-19 and Strategies for Mitigation and Suppression." Accessed November 29, 2021. https://www.imperial.ac.uk/mrc-global-infectious-diseaseanalysis/covid19/report12-global-impact-covid-19.

Wells, Chad R., Meagan C. Fitzpatrick, Pratha Sah, Affan Shoukat, Abhishek Pandey, Abdulrahman M. El-Sayed, ... and Alison P. Galvani. 2020. "Projecting the Demand for Ventilators at the Peak of the COVID-19 Outbreak in the United States." *The Lancet Infectious Diseases* 20, no. 10: 1123-1125. https://doi.org/10.1016/S1473-3099(20)30315-7.

Weyer, Jacqueline, Antoinette Grobbelaar, and Lucille Blumberg. 2015. "Ebola Virus Disease: History, Epidemiology, and Outbreaks." *Current Infectious Disease Reports* 17, no. 5: 21. DOI: 10.1007/s11908-015-0480-y.

World Health Organization. 2020. "COVID-19 virtual press conference 25 March 2020." *World Health Organization*, March 25, 2020. Accessed June 6, 2021. https://www.who.int/docs/default-source/coronaviruse/transcripts/who-audio-emergencies-coronavirus-press-conference-full-25mar2020.pdf?sfvrsn=abe86e92_2.

_____. 2020. "COVID-19 Situation Update for the WHO African Region." *World Heal Organ*, 1-5. October 7, 2020.

_____. 2020. "Health Topics. Coronavírus. *Coronavirus: symptoms. World Health Organization, 2020a."* https://www.who.int/healthtopics/coronavirus/.

_____. 2021. "Coronavirus disease 2019 (COVID-19) Dashboard." Accessed November 29, 2021. https://covid19.who.int/.

Yancy, Clyde W. 2020. "COVID-19 and African Americans." *Jama* 323, no. 19: 1891-1892. doi:10.1001/jama.2020.6548.

Zu, Zi Yue, Meng Di Jiang, Peng Peng Xu, Wen Chen, Qian Qian Ni, Guang Ming Lu, and Long Jiang Zhang. 2020. "Coronavirus Disease 2019 (COVID-19): A Perspective from China." *Radiology*, 200490. doi: 10.1148/radiol.2020200490.

ABSTRACT

The rapid spread of the novel Coronavirus disease (COVID-19) is a significant global health and economic concern. In sub-Saharan Africa (SSA), there is an emerging securitization of its perceived threats due to socio-economic inequities, inadequate healthcare systems, and the prevalence of diseases in the region. In other words, it is presented to the public as an existential threat with its attendant framings projecting a grim picture for COVID-19 hospitalization, mortality, morbidity, and pandemic response in SSA. We adopt a desk-based approach predicated on a critical exploration of securitization theory in examining SSA responses to the COVID-19 pandemic. We argue that COVID-19 securitization in Africa is exaggerated, with pessimistic generalizations that do not consider the local conditions and efforts by governments and the African Center for Disease Control in managing the pandemic. Rather than over-securitizing COVID-19 threats in SSA, we suggest that the region's local realities, age structure, level of urbanization, self-help capabilities, socio-political contexts, and available resources be considered in any pandemic mitigation strategy.

KEYWORDS

COVID-19. Securitization. Sub-Saharan Africa. Pandemic Response. Inequities.

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