

AFRICAN REGIONAL AND INTERNATIONAL COORDINATION: HOW COVID-19 ADVANCED INTEGRATION TRENDS AND SOUTH-SOUTH COOPERATION

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Introduction

COVID-19 was first reported in Africa in February 2020 and, as in the rest of the world, had an overwhelming impact. Projecting the gravity of the situation, the Africa Centres for Disease Control and Prevention (Africa CDC) alongside the African Union (AU) and most heads of states had started to prepare the continent since mid-January. In general, African countries sought to act before the situation was out of control, adopting strict measures.

While the early adoption of a cautious approach prevented the importation of new coronavirus cases into the continent, it had an impact on the lives of many Africans, particularly informal workers who relied on travel and commerce for a living. On a larger scale, the pandemic's disruption of global markets impacted many African states that rely on external trade, at a time when foreign direct investment (FDI) in the continent reached its lowest level since the 1990s, with a flow 30% lower than during the 2008-2009 crisis (UNCTAD 2021). These economic difficulties, however, came at a time when state expenditure was most necessary, as the pandemic reinforced the need for investment in healthcare, infrastructure (including supply networks) and security (border control).

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In this challenging economic and sanitary scenario, African states had to deal with a highly competitive market for medical supplies, from personal protective equipment (PPE) to reagents and vaccines. Furthermore, the very diverse situation within Africa, with some countries having advanced medical research and others lacking even basic human resources, meant that a common strategy towards COVID-19 had to include some sort of mutual support, allowing states to share technologies and public health strategies. These obstacles encouraged a united response to the pandemic on the continent. Adopting a common plan, at least in some core aspects, made it easier not only to optimise resource allocation, but also to avoid political friction. A common African position was also stronger when dealing with external partners, donors, and even sellers of disputed goods.

Considering these circumstances, this paper analyses Africa's readiness to confront the pandemic of COVID-19 and the role of South-South Cooperation (SSC) in this crisis. Our article presents the findings of a previous stage of a research project about COVID-19 effects in Africa. We analysed primary sources, including government documents, legislation, and speeches, as well as newspaper reports on African countries' responses to COVID-19. The data was collected throughout 2020 by the Brazilian Centre for African Studies (CEBRAFRICA) team. Through a qualitative analysis we compare information from this database with previous academic research on African regional organisations and SSC, thus examining the trends of regional and international coordination by African actors.

Our main argument is that by acting together, African countries could overcome regional asymmetries and collectively plan guidelines that could improve future crises responses. African countries were innovative and developed good practices to address the present crisis, which shows that they can, in the long term, build a robust integrated continental emergence healthcare system. Our data also shows that beyond the confluence of African responses, the high quality of foreign relations with partners such as China and Cuba improved the ability of African states to deliver a better response and get faster access to vital supplies.

Although Tanzania, Burundi and Madagascar had their own internal agenda to deal with COVID-19, when we observe the 54 African states, these three become exceptions. And even within the continent, each region has its own internal dynamics and restraints; overall, they are vastly trying to cope with many similar challenges. Historically, African states, despite their singularity, have found common objectives and projects to push forward, which is testified by the existence of continent-wide initiatives, such as the African Group at the United Nations, which dates to 1958, the Organisation of African Unity, established in 1963, and the AU itself.

This paper is divided into three sections. The first section discusses the challenge that COVID-19 posed for African states in terms of public health policies. The second section demonstrates that the first policies implemented during the COVID-19 crisis followed a pattern of coordinated response. The AU and African Regional Economic Communities (RECs) played a critical role in preparing a response to the pandemic. In the final section, we examine how the challenges posed by COVID-19 have affected broader aspects of African states' foreign policy, particularly how SSC regained its appeal and how the AU and Africa CDC developed policies to ensure that Africa had a saying in global negotiations.

Health challenges and the creation of the Africa CDC

The precariousness of healthcare systems in African post-independence states has been a historic problem. Inheriting a colonial structure, which largely overlooked the needs of the local population, post-independence African states would have to invest large sums to build infrastructure, educate healthcare professionals and create a network able to reach all of their territories. However, this necessary investment was seriously compromised, at first, due to civil wars, interstate wars, and patrimonial regimes; and in the 1980s and 1990s by the austere economic policies adopted.

Despite the modernising ideology of the African liberation movements, the continent was still, in the 1980s, largely dependent on the export of raw materials and import of industrialised goods (Amin 1995). World Bank specialists linked the slow pace of African development to the misuse of state institutions, as well as to corruption. They advised on restricting the size of the state and encouraging private enterprise. Although many African countries contested this view – and even produced their own document, the Lagos Plan of Action, arguing that external shocks, such as deteriorating terms of trade for primary products and growing debt were the main reason for Africa's underdevelopment –, the International Monetary Fund and World Bank prevailed in making Africans commit to structural adjustment policies.

During the 1990s, African states worked on a very limited budget for social and economic investment, prioritising external commitments instead. The 1980s and 1990s are largely considered “lost decades” for the African continent, as their economies were seriously contracted. This led to stagnation in various aspects, including healthcare. By 1999, Africans were considerably poorer than they had been 25 years before: while in 1975, Sub-Saharan Africa's regional GDP per capita stood at 17.6% of the world per capita GDP, it dropped to 10.5% in 1999 (Arrighi 2002).

While in 1972 African countries invested on average 6.2% of their GDP in healthcare, in 1982 it was about 5.3% and in 1995 only 1.6% (Anaemene 2020), putting their health infrastructure in jeopardy. Indexes such as life expectancy at birth, as well as infant mortality rate went through a phase of no improvement. By the beginning of the 21st century, infectious and parasitic diseases accounted for more than 40% of deaths in the African region, with malaria accounting for 7.6% of deaths and HIV/AIDS, 12.4% (WHO 2020a). Immunisation coverage was low among 1-year-olds. Less than 70% of births in Northern Africa and only 42.4% in Sub-Saharan Africa were attended by skilled health personnel, which led to a high maternal mortality ratio. The number of new HIV infections was the highest in the world and 32.5% of children under five years old were stunted (WHO 2020c, 65).

According to data from the World Health Organisation (WHO), in the early 2000s African countries employed only 3% of the world's healthcare workforce and accounted for less than 1% of world health expenditure, but had to deal with 24% of the global burden of diseases (WHO 2006). Domestic government health expenditure stood at only 1.59% of gross domestic products in Africa in the beginning of the century (WHO 2021b). External resources were becoming increasingly important in meeting the continent's needs. In 1995, nine African countries relied on external resources for more than 15% of their total health expenditure. This number had risen to 19 African countries by the year 2000. To meet the minimum healthcare needs of its population, the African continent became heavily reliant on international assistance. In 2009, Africa received 40% of all global health aid (Anaemene 2020).

One of the consequences of this scenario was the increase of new actors in the sector, as international health assistance is often not directed to support national healthcare systems but is channelled to NGOs and international organisations. In 2008, there were more than 40 bilateral donors, 26 UN agencies, 20 global funds and other 90 active initiatives providing health services in Africa (McColl 2008, cited in Anaemene 2020). This situation has led to a fragmented system of health assistance. Instead of joining forces to achieve more ambitious goals, these different actors are limited by their own structures. Also, without proper communication and coordination, redundancy was likely to happen. A fragmented architecture also harmed transparency and accountability efforts (Anaemene 2020).

Another issue with external aid is that it is typically directed to specific projects rather than improving national healthcare systems. This contributes to the development of dysfunctional systems, with poor policy management and investment prioritisation. Countries that lack a strong national health institution are forced to rely on external resources to provide healthcare. Long-

term strategies and planning are hampered because donors rarely commit to long-term projects. Furthermore, donations are frequently misdirected toward sectors that are important to donors rather than the country's true needs. As a result, African states are forced to accept policies that they did not design and do not necessarily want (Patterson 2018; Anaemene 2020).

By the end of the 20th century, the African continent was mired in stagnation, marginalisation, and reliance. To overcome these challenges, African leaders decided to revive the concept of Pan-Africanism, popular in the 1950s and 1960s. Continental integration through a stronger organisation was the strategy agreed upon in order to bolster autonomous economic growth, peace and an improvement in standards of living (Mathews 2011). In October 2001, in Abuja, Nigeria, the New Partnership for Africa's Development (NEPAD) was adopted, and in July 2002 in Durban, South Africa, the African Union (AU) was established.

The AU was intended to act on various fronts related to development, including healthcare – an area in critical need for investment and planning. Acknowledging that individual states lacked the budget for adequate healthcare expenditure, and that external donors that had the means to invest often couldn't address bigger-picture issues, the AU focused on advising local governments and foreign partners towards more efficient action, often encouraging that they joined forces. Member states agreed on a document, the African Health Strategy (AHS), which recommended efforts towards the most urgent health issues as well as towards longer-term regional goals. It was an eight-year plan (2007-2015) designed to serve as a continental guideline. Unlike national governments, which often didn't have the means to press donors into investing in certain areas, the AU, as a representative of 54 (currently 55) member states, could be more appealing.

The AHS contributed to the continent's significant progress in dealing with epidemics such as HIV and malaria – issues that require constant engagement and investment, as well as coordinated action in various areas of public service. Between 2007 and 2015, access to HIV treatments increased from only 10% coverage among people living with HIV to 51% and new infections declined (WHO 2020b). In Sub-Saharan Africa, between 2000 and 2015, the estimated number of malaria cases dropped by 42% and the mortality rate declined by 66% (African Union 2016). By 2015, the impact of infectious and parasitic diseases as a cause of death in Africa had been reduced to 31,6% (WHO 2020a). Although AIDS remains among the leading causes of death in regions such as Southern Africa, throughout the continent deaths due to HIV/AIDS halved between 2000 and 2015, from 12,4% to 6,7%, respectively (WHO 2020a).

Another aspect of the AU's role as a game changer in the health sector was that of coordination above national boundaries. This became clear during the 2014 Ebola epidemic, which amounted to more than 28,000 cases and over 11,000 deaths from March 2014 to June 2016 – a strikingly high number, compared to the cumulative sum of past episodes from a period of 32 years (1976-2012), which had 2,232 infected people and 1,503 deaths (Wapmuk, Jaji, and Wapmuk 2015). It was the first time that Ebola cases were imported via air travel, reaching Nigeria, Senegal, Spain, Italy, Germany and the United States of America.

The outbreak showed how ill prepared the affected countries were for such a crisis: although it started in Southern Guinea in December 2013, it went unreported for three months, which contributed to its rapid spread (Wapmuk, Jaji, and Wapmuk 2015). There was also inadequate control of rural-urban connections; as well as a lack of trained workers familiar with Ebola, which resulted in many of them contracting the disease (Patterson 2018). In this scenario, the AU launched the African Union Support to the Ebola Outbreak in West Africa (ASEOWA), in August 2014, to help contain the spread. Due to AU's ability in recruiting doctors and nurses through ASEOWA, the majority of foreign medical teams working on the ground were African professionals (WHO 2021a), followed by Cubans and Chinese.

The Ebola virus spread quickly during the 2014-2016 outbreak, and the fact that, unlike previous outbreaks, it reached major cities and even other countries drew public attention to the virus. As other consequences, particularly economic ones, became apparent, it became clear that Ebola and other potential health threats needed to be addressed as serious issues. AU member states urged the institution in September 2014 to expedite the establishment of the Africa CDC, including the enhancement of early warning systems to address all health emergencies in a timely and effective manner (African Union 2014).

This technical institution was officially launched in 2017, in support of the public health systems of African countries, improving prevention, detection and response to public health challenges (Musabayana 2016). At the regional level, the Africa CDC works through the Regional Collaborating Centres (RCC), which have laboratories that compose the Regional Integrated Surveillance and Laboratory Network (Nkengasong et al. 2017).

In 2016, a second edition of the African Health Strategy was launched, aiming at a longer, 14-year period. The AHS 2016-2030 contained updates and placed the health strategy within the Agenda 2063, a continental strategic framework to seek sustainable and inclusive development. The 2016 guideline included lessons learned from the Ebola epidemic and stressed the importance of improving the coordination of disaster response. It also

highlighted the need to reconstruct and reinforce health security in all African countries, once that the consequences of health emergencies are local, national, regional and continental (African Union 2016).

A continentally coordinated response

Decisions made at the provincial, national, and regional levels were critical to stopping the spread of Ebola by 2015. After declaring a state of emergency, the governments of Sierra Leone and Liberia, for example, were forced to order the closure of schools and markets (Mark 2014). This prior experience, not only with the ability to enforce such public policies, but also with the outcomes that they demonstrated for the epidemiological situation, put Africa ahead of other continents when the COVID-19 pandemic began, as similar actions were required.

Transportation was another area that required constant coordination for both Ebola and COVID-19. The Ebola epidemic taught Africans that controlling entry points had a significant impact on preventing the spread of viruses, both in terms of passengers and cargo. They noted that this effort was most effective when coordinated not only with neighbours, but also with other states that frequently exchanged with the most Ebola-affected countries. Regional organisations such as the Economic Community of West African States (ECOWAS), but also the AU, had to develop new protocols for regional interstate travel and put them before member states, who then had to quickly reach an agreement. Learning from this previous experience, when the new coronavirus started circulating in early 2020, Africans could rapidly detect the first cases among travellers and effectively reduce new imported cases to a minimum from an early stage.

Africa CDC started to prepare the continent for COVID-19 in mid-January, by activating its Emergency Operations Centre and the Incident Management System (Mo Ibrahim Foundation 2020). Even though the African continent is today better prepared for health crises, with substantial progress since the Ebola outbreak, most sub-Saharan countries have had their health systems operating at maximum capacity and the threat of a new disease would be a challenge (Kapata et al. 2020).

The African collective response can be divided into three major axes: prevention, detection, and surveillance. COVID-19 has a “multiplex impact” and thus requires a “multiplex” response: on healthcare systems, due to the average duration of treatment for each patient at hospitals, as well as the supplies demanded, including oxygen, ventilators, and protective

equipment; in the economic sector, due to operating hour restrictions and the exposure of workers to infections, particularly informal workers and supply chains; and on socio-cultural activities, because of school suspensions and interdiction of large gatherings.

Prevention, detection, and surveillance

One of the first major preventive measures for the crisis was the establishment of the Africa Task Force for Novel Coronavirus (AFTCOR)³, by the Africa CDC, alongside with WHO, AU Commission and national governments. The capacity to detect and contain diseases such as the new coronavirus was seen by the director of the Africa CDC, Dr. Nkengasong, as closely related to the capacity of African states to achieve their developmental goals, and should have, thus, elevated status of priority. The lack of adequate infrastructure to test for the new coronavirus affected laboratories' capacities, especially in small countries that had no technology to process PCR tests; in larger countries it was the lack of access to reagents which threatened the testing capacity (Instituto de Higiene e Medicina Tropical 2020).

Member states were committed to developing COVID-19 strategic plans, which were crucial in accelerating each country's response process. It also inhibited neglect and inaction, which in the case of African countries and COVID-19 turned out to be a very rare phenomenon. Most African states formed a multidisciplinary ministerial committee in charge of planning containment measures for the new virus, and the RECs were, since January, on alert regarding the disease (West African Health Organisation 2020; East African Community Secretariat 2020a; SADC 2020a) – even before the WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern.

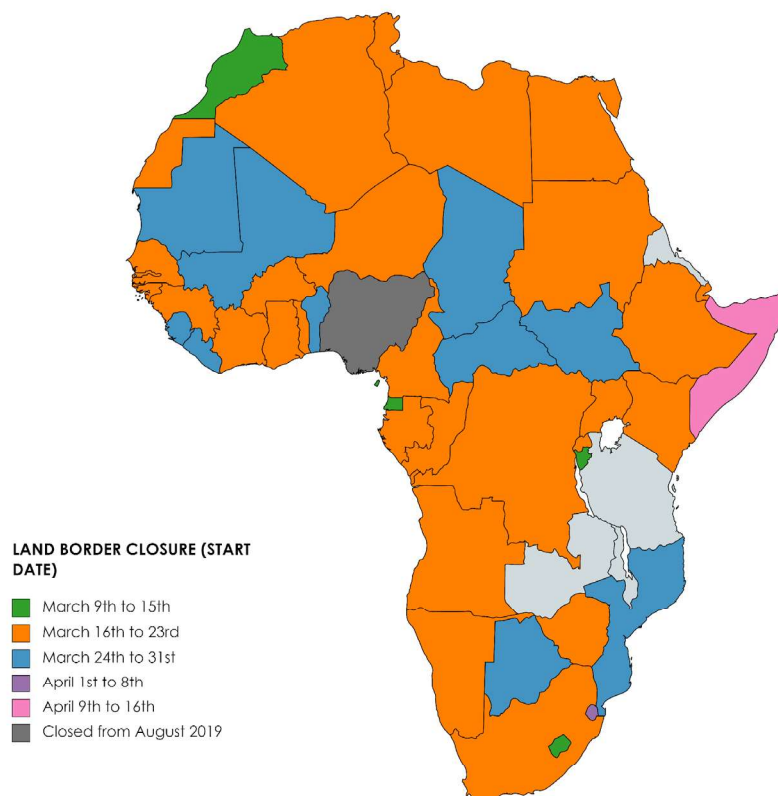
Community transmission in Africa was confirmed in March 2020, shortly after the WHO declared COVID-19 a pandemic. While the closure of educational facilities was a measure aimed at curbing the spread of the new coronavirus internally, additional measures were taken to prevent the importation of cases into each country's territories. Except for Benin, Zambia and Ethiopia, whose airports remained open to commercial routes, all other African countries restricted arrivals and departures to repatriation flights, humanitarian aid, medical transportation, and freight services. The observation of the timing of international commercial flights suspension indicates that there was high-level coordination in the region, as opposed

³ Other initiatives were developed by Africa CDC and African Union, but they are not our focus in this paper.

to individual country-specific measures. The restriction of air travel was less related to the confirmation of COVID-19 cases or deaths than it was to adopting the same timeframe as neighbours or regional commercial partners (Pereira and Kowalski 2020b; 2020a).

Additionally, land borders were also closed to passenger transit: only goods were allowed to circulate, and, in some countries, truck drivers were asked to take a COVID-19 test in order to be allowed to cross the border. In more than half of Africa's countries'⁴ domestic displacements were also restricted following the same logic, that is, maintaining the flow of goods but interrupting the transit of people. It is important to note that many Africans rely on informal sales to make a living – with workers travelling from rural areas to cities, or from one country to another to sell agricultural or textile products. These informal workers were greatly affected by travel restrictions and pressured governments to revert them. Despite the political cost, internal traffic restrictions and land border closure were maintained for most of the first semester of 2020 (Pereira and Kowalski 2020b; 2020a). Also, in the case of land border closures, there is a clear sign of coordinated action.

4 We found such measures in at least 23 countries: Algeria, Angola, Benin, Botswana, Burkina Faso, Cape Verde, Chad, Comoros, Congo (Brazzaville), Côte d'Ivoire, Gabon, Ghana, Equatorial Guinea, Eswatini, Ethiopia, Kenya, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sao Tome and Principe, and Senegal.

Figure 1 – Timing of Land Borders Closures

SOURCE: Map created with mapchart.net with data gathered from Pereira and Kowalski (2020a; 2020b).

Challenges and additional measures

Three major challenges in terms of COVID-19 response emerged in the earlier days of the pandemic in Africa: (i) delays of supply trucks at the borders due to the newly imposed restrictions; (ii) raising enough funds to implement stricter sanitary surveillance and prevention; and (iii) access to highly disputed supplies (such as PPE and test kits) in the international market. These issues were addressed both by the AU and by RECs.

Regarding the first one, in April, the Africa CDC arranged a meeting with the International Civil Aviation Organisation in order to make sure that

the urgent actions to contain the spread of COVID-19 wouldn't affect the supply chain of drugs, medical equipment and food (African Union 2020). Regionally, SADC and EAC member states agreed on guidelines for cross-border transit (SADC 2020b; East African Community Secretariat 2020b) and gradually larger agreements, for example between two or three regional organisations, were also signed, such as the COMESA-EAC-SADC Task Force.

The second major challenge was financing the implementation of the recommendations and preventive measures, especially laboratory capacity, purchasing test kits, training, and deploying almost one million health workers, and mitigating socio-economic impacts. The AU acted early on to address this issue, launching the Africa COVID-19 Response Fund (Kalondo and Manlan 2020). Regional banks, such as South Africa's Standard Bank, the Commercial Bank of Ethiopia, and the Kenyan division of Ecobank, as well as member states, contributed to the Fund. Moreover, Africa CDC has also received support from AU, WAHO, and external donors (Kapata et al. 2020).

Last, securing the supply of protective equipment was of particular concern among member states. Tests and lab resources were urgent, both to reduce the number of imported cases and to create public policies coherent with the actual situation of each country. Africa CDC and AU introduced in April the Partnership to Accelerate COVID-19 testing (PACT) to boost testing capacity and assure at least 10 million tests to help improve policies and guidelines (Africa CDC 2020b). Additionally, the AU launched in June the Africa Medical Supplies Platform (AMSP), in partnership with Afreximbank and United Nations Economic Commission for Africa (ECA). This non-profit platform enables AU Member States to purchase certified medical equipment and vaccines in a cost-effective and transparent way, by allowing volume aggregation (AMSP 2021).

The role of South-South Cooperation

South-South cooperation (SSC) is defined as cooperation guided by the principle of mutual benefit. Even in asymmetric relationships, it is possible to cooperate in a win-win environment in which partners can dialogue and gain more control over resource deployment, fostering a relationship of autonomy and political equality (Mello e Souza 2014). SSC is highly connected to the idea of development – not necessarily economic development, but the idea of expanding social welfare. In the mid-1950s and the beginning of the 1960s, the Bandung Conference and the Non-Aligned Movement were formed by states which had been marginalised of financial and scientific

progress, and which used these fora to claim for autonomy and development. They formed the Third World, a concept which has lost much of its popularity after the end of the Cold War, although the existence of a “geopolitical South” (Visentini 2015) is still very much alive.

COVID-19 pandemic has demonstrated, once again, how even when dealing with the same challenge, inequalities between countries lead to very different outcomes. During 2020, most African states struggled to acquire medical equipment. This was not only due to the lack of resources, but also because, in the scramble to access such products, Africans were frequently pushed to the back of the line, while more powerful states had priority. In October 2021, less than 15% of Africans had been vaccinated, while most North Americans and Western Europeans were receiving a third dose of COVID vaccines. Throughout 2020 and 2021, the WHO and the Africa CDC attempted to emphasise the importance of reconsidering international cooperation in order to have a better chance of fighting this crisis. In this sense, SSC has emerged as a means of advancing collective and urgent agendas.

External partners, traditionally engaged in Africa, have played an important role in supporting the continent during the COVID-19 pandemic. Western donors tended to focus on financing projects rather than sending direct support, with few exceptions (Pereira and Kowalski 2020b; 2020a). On the other hand, non-Western donors focused on deliveries of equipment, test kits, PPE, vaccines and/or the contribution of medical practitioners.

While it is difficult to compare these approaches, direct delivery of items has a faster impact in terms of COVID-19 response in a scenario of product shortage and urgent demand. At times during the pandemic, having the resources to purchase the most contentious materials did not guarantee that the country would have access to them. Learning from history, the lack of access to HIV antiretroviral drugs from the mid-1990s to the mid-2000s is estimated to have killed 12 million Africans (Nkengasong et al. 2020). Likewise, in the first months of the last major Ebola epidemic, in 2014, “many health workers died as a result of inadequate protective gear while caring for patients; ironically, a major material deficiency was the lack of rubber gloves – this in a region that had one of the largest exporters of rubber in the world” (Chaple and Mercer 2017, 143). After COVID presented similar procurement challenges, African regional organisations, such as the Africa CDC, advocated for the necessity to secure some level of self-sufficiency in terms of pharmaceutical products, considering their strategic role (Africa CDC 2020a).

Currently, 99% of vaccines used in Africa are imported, most of them through international procurement mechanisms (Irwin 2021). This has not always been the case. Some African states, such as South Africa, had the

capacity to manufacture vaccines in the past, but abandoned these programs in the mid-1990s (Makhoana 2013) due to the use of patents to protect products, structural adjustment programs (which compromised state budgets) and dependence on donors and international organisations, who do not necessarily buy from local producers. The African market remains highly influenced by the segmentation induced by the donor policies and multinational companies (AVMI, UNIDO, and WHO 2017). However, the empowerment of the African Union during the COVID-19 pandemic, covered in the first part of this article, and South-South cooperation, could change this game. The Africa CDC has set the goal of locally manufacturing 60% of the vaccines used in Africa within 20 years (African Union and Africa CDC 2022).

This section will look at two partners with a long history of working with African states on healthcare and SSC, as well as how they responded to Africa's request for assistance during the pandemic: China and Cuba. These two countries have had cooperation programmes with African countries since the 1960s, but scholars have had difficulty interpreting them. There is a tendency to interpret South-South programmes using the same theoretical framework as North-South aid, which leads to inconsistencies. For instance, China's cooperation with Africa was initially interpreted as a means for receiving diplomatic support against Taiwan. When its one-China policy became widely accepted and, still, cooperation continued, new theoretical interpretations had to be found and some scholars pushed the idea that the Asian country maintained cooperation with Africa in order to guarantee a supply of raw materials. However, there is an indication that China-Africa relationship surpasses the achievement of one-off objectives and tends to be maintained – and expanded – in the long term (Visentini 2011; Gazibo and Mbabia 2012).

The same applies to Cuba's cooperation with Africa. Despite many scholars regarding Cuba's presence in Africa because of its relationship with the former Soviet Union, Cuba actually maintained, and in some cases even expanded, its presence on the continent after the end of the Cold War. SSC is better explained in this context as a means of forming coalitions and facilitating collective action for change in the International System. Instead of being guided by economic pursuits (in the case of Africa, by the preservation of commercial strongholds and privileged areas of political influence), the South-South logic is guided by lessening interstate asymmetries (which constitutes a subversion of the current functioning of the International System). For this reason, SSC is less connected to specific or privileged geography (as opposed to "Francophone" Africa, the Commonwealth of Nations, or the Community of Portuguese Language Countries) and more related to common political projects.

That is not to say that South-South Cooperation is uninterested cooperation. In their international activities, all states are guided by national interests. While North-South cooperation lacks political will to change the status quo (the existence of a geopolitical “North” and a geopolitical “South”), SSC is actively attempting to transform the international system to break the North-South divisions. Again, this transformation is not about “winners” and “losers”, nor is it about a specific state overcoming underdevelopment (as the case of South Korea, to cite one). It attempts to shift from “individual” logic to “collective”, or common logic. This is done not as a noble or “solidary” act, but because it is understood that the North-South disparity can only be overcome by sharing technology, knowledge, and, in some cases, resources (capital).

Bringing this idea to our subject matter, healthcare is a sector historically crossed by a North-South divide. Structural adjustment programs, largely pushed to low-and middle-income countries by Western lenders, have had a crippling effect on social policies, including healthcare and education, in the developing world. While North-South aid programs can be generous in this area, the lack of involvement by recipient institutions has led to a perpetuation of dependency (when not directly a dependency on donor countries’ aid agencies, at least a dependency on NGOs or international organisations). On the other hand, SSC in this area usually involves a smaller budget, but more technology transfer, in the sense that public officers and healthcare professionals exchange their successful experiences with local authorities.

Pharmaceutical know-how and manufacturing have been a more visible source of North-South conflict. Patents, and intellectual property rights in general, have been a source of contention since the Uruguay Round of talks in 1994. By the end of the 20th century, the 15 largest pharmaceutical companies in terms of global prescription drug sales came from only five countries: the United Kingdom, the United States, Germany, Switzerland, and France (Turshen 2001). In terms of vaccines, in mid-2008, five major firms accounted for more than 80% of global revenue (WHO, UNICEF, and World Bank 2009). South-South Cooperation in the pharmaceutical sector could thus challenge this highly concentrated market by multiplying the actors capable of not only manufacturing products, but also of developing their own patents, thus breaking a path of dependency, and weakening the institutions that benefit from the status quo.

Cuba

From the first days after the Revolution, Cuba has sought to aid national liberation movements and anti-imperialist groups around the world. This has led to the Caribbean island to be highly involved in African politics in

the 1960s and 1970s, when revolutionary anti-colonialist movements were in full swing (González 2020). Cuba was the only economically underdeveloped country to carry out a foreign policy towards Africa comparable to that of the superpowers (Pereira 2016). In fact, until recently, Cuba played a larger role in Africa than China did. Cuban support was not only military or diplomatic, but also a hands-on approach which included the education of professionals in strategic fields, including medical and pharmaceutical work. From as early as 1962, the first Cuban medical brigade arrived in Algeria.

Despite the economic challenges of the 1990s, Cuba maintained its programs for cooperation in health in Africa. It also maintained scholarship programs at local medical schools – only from South Africa, more than 3,000 doctors have graduated in Cuba. Additionally, this was the moment when, after the rise of the Cuban biotechnology industry a decade earlier, Havana was signing technology transfer deals for pharmaceuticals with many partners. Cuba had, in 2009, more SSC programs in biotechnology for health than India, South Africa, Brazil, Egypt and even China. In Africa, it established technology transfer deals with Algeria (Saïdal Groupe) and South Africa (Biovac) for the Hepatitis B vaccine (WHO, PAHO, and European Commission 2015).

During the Ebola Epidemic of 2014, when the WHO issued a call for medical collaboration, Cuban authorities responded immediately by sending 256 health professionals. “This was the largest single group of specialised collaborators who went to work in the affected region. Many more were needed, but except for Cuba’s, the international response was low and slow” (Chaple and Mercer 2017, 144). Aside from the specialists working directly with Ebola, there were 32 Cuban medical brigades active in Africa in 2014, with 4,048 professionals (González 2020).

In 2020, the same situation happened: aside from around 4,000 Cuban medical professionals working in Africa, when COVID-19 struck the continent, specialists were sent to 11 African countries in 2020, as well as to Gabon and Mozambique in 2021. Cuba has also offered a technology transfer deal to enable manufacturing of its “Soberana 2” vaccine in Ghana (Ghana FDA 2021).

China

China-Africa long-term cooperation agreements in healthcare dates back to 1963, when the first Chinese doctors arrived in Algeria. Chinese Medical Teams have been highly valued by African governments since then and medical cooperation has greatly increased, with more than a thousand active physicians in the continent (Li 2011; Brautigam 2009).

During the Ebola outbreak in 2014 in West Africa, China played an important role to halt the disease by sending money, medical supplies (PPE, sterilisation equipment and drugs), and around 1,000 doctors, some of whom were already working on the continent (Cui 2019). Focusing on long-term development and empowerment, China also invested in public health facilities and in training local health staff (by 2015 they had trained more than 10,000 professionals). At the second Ministerial Forum of China-Africa Health Development held in October 2015, “China pledged to send 1500 medical workers (...), and it encouraged ten of its large pharmaceutical and medical equipment enterprises to cooperate with various African counterparts” (Cui 2019, 167), including through technology transfer.

Since then, health has been considered a priority in terms of China-Africa relations. In the 2018 Beijing Summit and 7th Ministerial Conference of the Forum on China-Africa Cooperation (FOCAC)⁵ China has committed to scale up medical assistance to African countries and promised to build a facility for the Africa CDC (Ministry of Foreign Affairs of the People’s Republic of China 2018). This relates to China’s new approach in terms of medical cooperation with Africa. Despite the historical presence of Chinese doctors on the continent, and despite its infrastructure investments in the early years of the 21st century, China recognized that it could make a stronger impact on Africa’s healthcare system by supporting regional organisations, especially in terms of access to basic drugs and medical supplies (Alcorn 2015).

China’s aid to Africa in terms of the COVID-19 pandemic was focused on supplying the most urgent and disputed resources at different moments of the pandemic. It delivered supplies, including PPE, ventilators, thermal screening gates, test kits and reagents during the first half of 2020 (Pereira and Kowalski 2020b). In the first semester of 2021, China sent several donations of its anti-COVID-19 vaccines: around 4.9 million doses had been delivered by April 2021 (Development Reimagined 2021). Also, Beijing didn’t interrupt any of its agreed-upon medical missions to African states. On the contrary, they sent new teams of specialists, including professionals who had been on the front line in Wuhan. During the pandemic, China and Africa increased high-level health exchanges, with Chinese specialists with experience in the COVID-19 crisis counselling at least seven African countries and opening health centres in Africa throughout 2020 (Pereira and Kowalski 2020a; Xinhua 2020).

5 The Forum on China-Africa Cooperation (FOCAC) was created in 2000. It is a triennial forum, which involves a high-level conference, where Action Plans and Declarations are prepared, as well as a follow-up mechanism to assure the implementation of the Plans.

Conclusion

This paper reviewed the major challenges that the COVID-19 crisis has imposed on African countries, especially during its first wave in 2020. As argued, through collective measures, regional institutions such as the AU and Africa CDC were able to coordinate the pandemic response since before it reached the continent. The data showed a synchronised adoption of public policies, which reinforces the hypothesis that African countries were seeking to act concertedly. Also, it is important to have in mind that the Africa CDC didn't intend to set universal measures, nor to compel members into taking a specific approach towards the new virus. Its main goal was to serve as a coordinating body from member-state level up to a regional, regional-adjacent, and international level. That is, its objective was to serve as a reference, supporting each state with accurate information, expertise, supplies, etc.

Secondly, we note that self-sufficiency turned into an even more important issue to African leaders after it became clear that the currently installed pharmaceutical capacity would not be able to supply all interested parties on a global scale, leading Western countries to pressure companies to care for them first. This reopened a discussion about Africa developing its own production capabilities for drugs and vaccines. Stimulating local pharmaceutical production would generate a spillover effect, creating employment for higher-qualified professionals and avoiding "brain drain". It would also contribute to most African countries' goals of industrialising.

While each individual African country acting separately had little bargain capacity to push for more ambitious technology transfer deals in terms of pharmaceuticals, the strengthening of African continental institutions after COVID-19, especially the renewed key role of Africa CDC, has enabled the signing of longer-term projects, which could be the cornerstone for guaranteeing the manufacturing of strategic pharmaceuticals within Africa (and thus avoiding dependency) in the future. For decades, Africans have been struggling to ensure a steady supply of vaccines for its population, as industrialised countries have become uninterested in producing cheaper immunisers. As it turns out, COVID-19 could set the process of local procurement for these products. By summoning its historical SSC with China and Cuba, African leaders have pushed for technology transfer deals regarding the new coronavirus vaccines, which could be later enlarged to encompass other pharmaceuticals.

In the long-term, Africa should focus on expanding its infrastructure with the goal of decreasing its reliance on external aid, avoiding fragmented action and setting its own priorities. Through Pan-African institutions, and acting as a united front, Africa can step up and set its own

development path. Also, it should focus on relations that transfer technologies and improve local people's skills. In the context of the COVID-19 pandemic, the geopolitical axis of South-South Cooperation demonstrated the potential to contribute to Africa's autonomy.

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ABSTRACT

Africa is one of the world's forerunners in terms of political integration. Already in the 1960s, the Organisation of African Unity had 32 states united under a common charter. Moreover, through joint projects with Latin American and Asian partners, African states have joined some of the primary experiences of South-South Cooperation, particularly in the areas of healthcare and infrastructure. Taking this historical context into account, this paper examines how the highly competitive reality of the COVID-19 pandemic has impacted the continent. We argue that the constraints imposed by the new coronavirus outbreak have strengthened the African Union's role in advancing collective action and encouraged self-sufficiency. Furthermore, we analyse how South-South Cooperation offered a platform for immediate response when access to disputed medical supplies in the world market was difficult. We conclude that the COVID-19 crisis has contributed to consolidating African regional integration in the long-term, as well as its coordination with partner emerging countries, with consequences for the African Union's priorities in terms of foreign affairs in the future.

KEYWORDS:

African Union. Africa CDC. COVID-19. Public Health. Pan-Africanism. South-South cooperation. African Regional Economic Communities.

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