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Covid-19 and the Return of the State in Africa

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ABSTRACT
As African countries battled the Covid-19 crisis in 2020, one of the questions that were raised was whether the state was taking a central stage in the affairs of society, especially solutions to major problems. The question was triggered by the fact that there has been a decline in the capacity, role and prestige of the state in Africa for decades. Yet it seems that the responses to Covid-19, following the WHO guidelines, have placed the state at the centre, without dislocating other stakeholders like the private sector and the civil society. This paper uses the evidence from a select number of African countries of different sizes in various regions of the continent to provide an empirical perspective on the role of the state in Covid-19 responses in 2020 to answer the question of whether Covid-19 has occasioned a return of the state, thus reversing the neoliberal designs in favour of a lean and mean state in Africa.

KEYWORDS Covid-19; state; Africa; public policy; capabilities

The argument

The arguments and efforts to limit the role of the state in providing essential services to people have gathered momentum in the age of neoliberalism and its mantra of lean and mean state, paving the way for privatisation of public service. These efforts helped diminish the presence of the state and its capacity to participate actively in ensuring people's universal access to essential services like health care and education. The poor and working people have suffered disadvantage further compounding the socioeconomic deprivation brought about by the neoliberal onslaught on the inclusive economy that led to growth in unemployment and poverty in developing countries with African countries among the worst hit. These conditions have eroded the social capital necessary for the poor to cope with emergencies and weakened poor communities' resilience against structural crises. The Covid-19 calamity is one of the worst to affect poor communities in Africa in decades. The disease did not only cause widespread sickness but also increased levels of anxiety and stress. It further led to a terrible loss of jobs and economic opportunities. The world over the mantra of the small-and-lean state seems to have given way to the expectation that the state must take full control of social services while underwriting the private sector's efforts to cope with the economic ramifications of the pandemic. This paper critically reflects on whether the Covid-19 pandemic is reversing the neoliberal limitations on the state's role in social services and the economy. The answer to this is the basis for anticipating what might become of the state role after the pandemic. The paper draws from the experiences of a select group of countries in Africa. The aim is to

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understand our analytical question based on countries that have seen the neoliberal onslaught on state and development.

The shrinking state

The literature on the evolving role of the state in the global South and Africa, in particular, is rich and diverse. In Africa, the focus can broadly be categorised into three areas. The first is what has been called the inheritor state (Forje 2011). The second is on the stare and structural adjustment (Mkandawire 1995). The third is the developmental state discussion (Mkandawire 2012). All of these strands of discussions loosely categorised in this way have at the centre concerns and contestations about the constitution of the political. We are talking about a debate about how political power is understood. It is about how it is institutionalised through statehood and how it governs society to benefit citizens.

This matter of the constitution of the political that I suggest undergirds discussions on the state and society diverge along ideological and theoretical grounds. A few of these paradigmatic lines may be briefly pointed out here. There is a strand that may be said to belong to mainstream democratic theory's line of arguments, that privileges the question of whether the state is suitable for and is facilitating democratic consolidation (Sklar 1983). This strand is concerned with the democratic credentials of the state in relation to enabling a sound rule of law, the protection of individual freedoms and rights, ensuring accountability and responsibility, and service provision (Mattes and Bratton 2007). This theoretical commitment leads to concerns about states and their involvement in curtailing the freedoms of citizens and political actors like opposition parties. The concerns are also about the concentration of power in the executive at the expense of the legislature and citizens. The discussions on the state in this frame of analysis are dominated by discussions on such issues as the dominance of governing parties including liberation movements in the case of Southern Africa, the problem of authoritarian regimes and dictators, the harassment of opposition parties and critical civil society, the quality of elections and post-electoral developments, and citizen uprisings for human rights and freedoms (Saul 1994; Southall 2013, 2005). The discussions show concern about whether a country's democracy is consolidating or not.

There are also discussions informed by critical political economy. This is a perspective that is concerned about the implications of the political economy of capitalism on the democratic experiences of African countries. In this, I include discussions that seek to understand the extent to which primitive capital accumulation altered the role and function of the state (Okafor, Smith, and Ujah 2014). The rise of neopatrimonialism and how it transformed the state in Africa, for instance, into an instrument for rent-seeking and kleptocratic politics through a small political elite amassed wealth and crude state power (Mkandawire 2015). The growth in political corruption was not just about diverting resources to the rich but also about maintaining a parasitic relationship between the bourgeois elite in Africa and its counterpart in the rest of the world (van der Walle 2007). The challenge of the state was therefore also its entanglement with exploitative and corrosive tentacles of the capitalist world system. This world system maintained and reinforced global inequality that kept African economies on the periphery and thrived on African states operating as clientele states rather than fully sovereign states.

This leads us to the third strand of the discussion. This is a discussion that has gained momentum in the post-Cold War era. It is partly a product of debates on the democratic state where the matter of the relationship between democracy and development was placed on the table (Ake 1996; Mkandawire 1999). In this, the discussions included the view that liberal democracy creates conditions for the market economy to thrive as it promotes individual freedoms and rights, protection of property rights, and rule of law as conditions for a thriving liberal economy. Yet whether democracy precedes development or vice versa would be a question emerging from the political economy discussions where the quality of life of the people, shared prosperity, redistribution of wealth and reduction of inequality were seen as necessary for democracy to have a social base and a positive bearing on the people. This democracy – development nexus became even more pertinent as the growth of democracy in Africa became obvious after the end of the Cold War, but there was no improvement in the quality of lives in terms of socio-economic conditions (Ake 1996). Poverty levels grew as democracy spread. Inequality deepened as democracy consolidated on the continent. Levels of deprivation rose even as regular elections became a norm. Increasingly, it became common to have a democratic government based on an exemplary constitution and all the right laws yet the same country is haunted by disillusionment and underdevelopment (Zack-Williams 2001).

It is in this context also that the idea of a social base for democracy emerges. It is an attempt to find a way in which democracy can be built in a way that addresses the socio-economic needs of the ordinary people (Shivji 2003). The criticism of liberal democracy was that the elite who thrive in liberal democracy and its economic approach dear the power of masses and therefore they prefer a representative democracy. This democracy limits the role and agency of the ordinary. It limits the people to the actions and choices of the representatives often drawn from among the elite after elections. It produced a choiceless democracy (Mkandawire 1993), and garrison democracies whose strength was the ability to use the hard instruments of state power against citizens (Adejumobi 1998). The elitism in democratic politics reinforced and deepened the aloofness of the state and the callousness of the market and economic elite (Nzongola-Ntalanja 1987).

The idea of a social democracy that was seen delivering more shared socioeconomic outcomes than did liberal democracy attracted African thinkers and political actors alike (Shivji 2003). This type of democracy hinged on a strong and capable democratic state ensuring that the benefits of prosperity trickled down to the poor or was used to cushion the poor from the vagaries of a volatile economic system (Mafeje 1995). This state intervened through a comprehensive social welfare system and economic incentives to lift the quality of lives of ordinary people. It required and created conditions for a free-market economy to thrive to deliver on its lofty social goals. This democratic state was being used in pursuit of socialist outcomes, something that made it attractive to Africans hoping to see socioeconomic promises of socialism without building a fully socialist system (Mafeje 2002).

Partly out of this emerges the debate about whether you could have democracy and development at the same time. This leads us to the idea that a new form of state could emerge that could deliver this end. The developmental state idea is drawn from the experience of East Asia. While Africa was contending with the neoliberal idea of the lean and mean state, East Asians built strong states capable of intervening in the economy to advance development outcomes. Crucial in the debate is that because it

was said that society needed the state to play a central role in ensuring equitable and inclusive economic development, the capacity, character and conduct of the state became an important consideration (Matlosa 2007). The capacity to plan economic development in both long and short horizons entailed developing development plans to guide the building of a prosperous (Edigheji 2010; Mkandawire 1999). It means the ability to enforce these plans, ensure they are integrated and measured. This entailed a high level of technical skills that were needed in the state.

The capacity of the state to intervene effectively and systematically in the economy without displacing the private sector, but enabling it to derive its profits from the directions that the state decides was seen as important. This is the capacity to understand where collective good interfaces with the interests of capital, the convergence between building a prosperous society and the profit-making interests of the private sector. It is the ability to influence key social partners to align themselves with national plans, finding their interests to pursue in these plans. The implication of this was the need for the professionalisation of the public service and a greater focus on meritocracy in the appointment of senior leaders in the public sector generally.

Yet, the debate included the question of just how does a state acquire this capacity to intervene in the political economy while becoming a democratic character at the same time (Edigheji 2005). Debates on the African continent responded to the idea of a developmental state to justify the building of authoritarian states that used the promise of development to excuse the dictatorship. This was rejected by those who argued that the idea of 'development now and democracy later' implied by dictators was an unfair sequencing of equally important needs of African societies (Gumede 2011). The demand was therefore for a democratic developmental state. This is about the building of a strong democratic state that can influence socio-economic development for the benefit of all in society.

The covid-19 crisis

The arrival of Covid-19 in Africa was witnessed in the first quarter of 2020. As far as evidence reveals, it was first transmitted mainly through travels between Africa and Europe where the virus quickly became virulent and devastating. This virus was first identified when it badly hit China in January 2020 and spread to all the regions of the world through the networks that serviced globalism and globalisation including air travel and sea travel. The infectiousness of the disease was observed in East Asia and Europe before it also manifested with devastation in North America, the USA, in particular. Initially, the incidence in Africa was mild except in North Africa, which is physically close to heavily affected southern Europe and South Africa, which is strongly linked in economic and other ways with Western Europe. Africa's figures remained below world averages and the effects in infection and mortality remained below expectations for most of 2020 (Wadvalla 2020). Yet the effects on social livelihoods even where the incidence was negligible were alarming still (Gabore 2020).

The strain on health systems in countries like South Africa, Egypt and Senegal became visible as hospitalisation increased and the demand for health facilities increased. Immediately, disparities in these countries became apparent. Shortages in personal protective equipment as basic as face masks happened to be both about inadequate supply in

regional supply chains and affordability for countries and individuals. The shortage of hospital facilities especially ICU beds as numbers of those in need of intubation increased in some countries such as South Africa, Botswana and Zimbabwe (Dyer 2020).

In countries like Zimbabwe, years of economic meltdown coupled with the weakening of social services and health care systems highlighted by years of doctors strikes exposed many to the vagaries of the Covid-19 pandemic with some devastating consequences (Makumbe 2003; Nyoni 2017). Across the continent, longstanding health disparities and weak health governance long highlighted limited the capacity of many countries to fight the Covid-19. The health responses that the World Health Organisation recommended assumed the existence of a functioning health system and governance, but this was either severely weakened or inadequate in several African countries.

Suddenly, the capacity to provide basic health care to its population on a comprehensive basis became a key determinant of success in the fight against Covid-19. The provision of health centres with adequate basic equipment and supplies became critical in response to COVID-19. Similarly, the availability of sound support chains for health products as well trained and properly paid health workers who are motivated to their job also became essential in the fight against Covid-19. A number of countries including more sophisticated and bigger economies like South Africa were shown to have major weaknesses in these areas.

The state capacity to provide other essential services was also tested. Critical among these is the provision of clean water. Communities without secure water supplies protested at government guidelines calling for the regular washing of hands. Covid-19 has therefore shone the spotlight on shoddy public service in basic areas. To prevent Covid-19 from increasing uncontrollably, governments have had to fix these problems.

Covid-19 has also increased the demand for mental health services as stress levels rise and psychological strain on citizens grew. In some cases, mental health services are already inadequate on many grounds including infrastructure, universal access and the quality of services. Links between Covid-19 and the spread of sense of unease, anger, despair, hopelessness is a matter for careful study, but suffice it to say here that indications are did-ease is accompanying widespread disease. If this is true, it will weaken the social capital that is essential for building social resilience against the disease.

International guidelines and state response

Covid-19 became a global pandemic within a few weeks of its emergence. The United Nations and the World Health Organization's guidance became a crucial source of ideas for governments. The first principle of this guidance was that countries needed to adopt what was called a comprehensive response to COVID-19. This entailed pursuing four key objectives: a response at the national, regional and global levels that leaves no one behind: reducing the vulnerability of society to future pandemics: build resilience to future shocks including climate change; overcoming systematic inequalities that exposed many to the pandemic (UN 2020). Therefore, the UN position, which countries were expected to emulate, tended to emphasise three pillars to attain the above-mentioned objectives: a large-scale, coordinated and comprehensive health response; policies that address the socio-economic, humanitarian and human rights aspects of the crisis; and

recovery plans addressing health and socio-economic crises that is termed building back better (*Ibid*).

So, the idea was that states needed to combine saving lives, protect societies and recover better. They needed to address fragilities and gaps that made societies vulnerable in the first place. The comprehensive response meant that states had to approach the immediate crisis in a manner that does not divert from long-existing structural crises such as inequality, poverty, unemployment and underdevelopment. The response must also not shift the state attention from future crises including the evolving crises that accompany climate change. The Covid-19 problem was quite early on recognised as not just a health crisis, but a socio-economic, humanitarian, political, security and human rights crisis. It affected individuals, families, communities and societies in ways that changed a lot about how they function as sources of social capital for responses to long-existing crises. It thus presented a risk to the resilience of society against future emergencies and crises. A response required would cause society and governments to think carefully and systematically about the structures of society and how all components of state and society cooperate for common good.

The World Health Organization (WHO) on its part and in line with the overall comprehensive response of the UN issued guidelines to guide public health responses. While it issued statements and guidelines as early as early January 2020, it released a comprehensive plan called 'Strategic Preparedness and Response Plan (SPRP)' on 3 February 2020. The SPRP required a whole-of-government and whole-of-society action adapted to national conditions. It provides for a phased transition from widespread incidence through the low transmission to a low transmission of the disease. The WHO strategy recognises and emphasises a renewed focus on public health. It thus makes the state leadership in ensuring comprehensive health response to the pandemic not only important but essential.

This public health response concentrated on three objectives: rapid identification of Covid-19 cases; timeous and as comprehensive as possible testing of suspected cases and vulnerable populations; and the treatment of infected people especially those showing signs of serious and severe Covid-19. To this end, public health authorities are advised to in place to stop cases from becoming clusters and clusters from becoming explosive outbreaks. This requires capabilities for testing and diagnosis, isolation, contact tracing and quarantine. These capabilities that public health systems are expected to have gone beyond personnel and skills but extend to technology and equipment. It is also the capability to mobilise all these capacities from the whole of society including through smart partnerships with the private health sector.

For this reason, the SPRP required states to demonstrate the ability to mobilise the whole of government and all sectors of society to take ownership of prevention and treatment of Covid-19, the control over the incidence of the disease, the suppression of cases, measures to reduce mortality and the development of safe and effective vaccines. 'Governments must lead and coordinate response across party lines' read the SPRP, 'to enable and empower all individuals and communities to own the response through communication, education, engagement, capacity building and support' (*ibid*, 6). Governments were advised to work with speed to repurpose available capacities in society to rapidly scale up the public health system to what has got to be done to achieve the objectives outlined above. The state was also required to mobilise resources inside and outside

the country, improve cooperation with other states to enhance public health capacities to respond. It is the duty of the state also in terms of SPRP to maintain and strengthen social services that support the public health response. The enforcement of controls, isolation, quarantines and the prevention of clusters from forming required capacities constitutionally given to states.

Coordination and planning were seen as critical for a comprehensive public health response to work. National public health emergency powers and measures give the state a greater role in managing national disasters like Covid-19. National distaste management or crisis management powers and capacities are required to enable the level of total coordination required. It is the duty of the state to provide and share Covid-19 plans with society for collective ownership and to do so in a manner that makes it easier for sectors to join forces in the fight against Covid-19. These plans, WHO advised, needed to include non-state actors like civil society formations and networks that can play a crucial role in the national response. These plans are then the basis on which the state mobilises support across society, galvanised sectors into joint actions, and engages in participatory community engagement to protect society and the vulnerable people, in particular (*ibid*, 7).

To suppress the transmission of the virus within and between communities leading to explosive outbreaks that overwhelm the health system, harm the economy and put livelihoods in jeopardy, the state is expected to take and enforce population-distancing measures and movement restrictions on top of other personal and community measures to reduce transmission. Restrictions must be designed to prevent the importation of the virus from high transmission areas to low or no transmission ones. These measures have the potential to also thus reduce mortality and flatten the trajectory of the epidemic. WHO warned that these measures are ' blunt tools with considerable social and economic costs"(*ibid*) and so communities must be informed of these risks and the participation be solicited. In implementing these measures, the state must aim to not harm.

Thus, these international guidelines required a responsible, reasonable, transparent, capable and caring state. Responsible states are those that take their duties to serve and lead society for common good seriously enough to act timeously and fully. They are reasonable and reasoned in their response and this case, this meant the ability to draw from health science, the science of planning and the science of governance. Such states have or know how to develop or enhance the requisite capacities to lead and coordinate comprehensive public policy responses envisaged by the UN and WHO's SPRP. The state implied is also one that is accountable and transparent, willing and able to enlist the support of all in society and ensure collective ownership. A caring state uses its powers, capabilities and resources to do no harm but to protect the population including the vulnerable from harm. Whether this state has in practice emerged and to what extent is a matter for debate. Below we survey generally how these states have behaved in response to COVID-19. Space does not permit a comprehensive systematic analysis of this point, but the first level of critical commentary is provided to open the way for subsequent analyses in some greater detail. We draw a bit from available surveys in Africa to support this commentary.

Covid-19 and the state in Africa

We argue that the role that the state has been thrust into in responses to Covid-19 has been remarkable in two ways. The state has been pushed into the position of leading the whole of society in comprehensive efforts to reduce the incidence and effects of Covid-19. The state has been looked upon to lead efforts to recover from the social and economic impacts of a disease in which individual and group conduct is catalytic. In relation to both responsibilities, we will show that the state role is big and consequential for debates on the developmental state or generally on the role of the state in modern democracies. The first responsibility is what is happening right now. The second is an extension of this state role beyond health and social services to driving economic recover. We do not deal with the latter in this paper due to inadequate space.

No one was surprised when one state after another took measures to enable governments to play a leading and dominant role to respond to a fast-growing problem of Covid-19. States decided on urgent measures that required emergency powers in the face of what seemed like an existential threat not because of its deadly nature but because of the magnitude of its effects on livelihoods and economies. It seemed that the state emergency measures were not only justified but necessary. The common refrain in media reports was states finally showing leadership in crises, following scientific advice and acting emphatically (Sarungi-Tsehai, Mugambi, and Farisani 2020).

After all, many Africans had observed the pandemic wreak havoc in Europe and the early stages in China and Oceania. They had observed just how virulent and brutal the disease was, and how devastating its health and social impacts were if left unchecked. The images of health facilities completely overwhelmed by sickness and deaths rising uncontrollably in some cases had already reached Africans before state emergency measures were taken. The benefits of social media and mass media were that Africa got warned and lessons had to be learned quickly.

Africans had also observed the power and effect of organised states leading society in successfully arresting this problem and limiting the effects. They had observed how China, South Korea, Taiwan, Singapore and others organised themselves for comprehensive whole-of-state responses. They had seen governments take control of the situation with aplomb, thus saving many from the vagaries. Governments quickly set out what society was to achieve and how. They quickly rolled out health measures accompanied by social and economic interventions, marshalling the whole society in a fight against a dangerous virus. Whether full, partial or soft lockdowns, the actions of the state became synonymous with exemplary behaviour all over Africa (Haider et al. 2020).

Indeed, the examples set by developmental states of East Asia would be replicated in African countries. Governments took the lead and dominated the responses to the Covid-19 problem. Like them, African countries like South Africa declared either a state of disaster or emergency in order to enable them to impose restrictions on people's movement and activities that were thought to cause the disease to spread easily and fast. It was to enable them to draw from funds reserved for dealing with disasters and emergencies to purchase personal protective equipment and other essential services. 'Indeed,' said one blog put it, 'from Cape Town to Cairo, many countries have seized the opportunity to combine both existing emergency health care protocols and innovation to improve

response effectiveness, from building affordable ventilators to using digital and emerging technologies for tracking and other economic activities' (Travaly and Mare 2020)

This was also in political terms a signal to the population to take the crisis seriously and to see the government and the political class as significant players. Through emergency measures, politicians acquired more power to present themselves as significant in society. They seemed to enjoy this new room to display their significance in society. It is this that caused a bit of difficulty for many societys, it is the excitement of politicians about riding on the emergency powers that would at times create discomfort and resentment. This led to talk of viral authoritarianism in response to Covid in the US, parts of Europe and in Asia (Gaspard 2020).

We look at Kenya, for instance, which is one of the states in Africa that have decent capacities both to manage the economy and public policy. The first case was reported in mid- March 2020 and soon rose astronomically. Yet ahead of this, the Kenyan government had long put measures to respond to the looming crisis. On 2 February 2020, long before there was a single case of COVID, the Kenyan government advised Kenyans to be vigilant by avoiding contact with persons with respiratory symptoms, to wash their hands with soaped water regularly, and visit nearest health centres on suspicion of infection. A week later, in fear of inward transmission, it advised against non-essential international travel. On 19 February, it set up a forum for various agencies to coordinate in response to impending infections. A week later, Kenya established in line with WHO guidelines the National Emergency Response Committee by an executive order to coordinate a multi-agency, multi-stakeholder response (Aluga 2020, 672). This is the committee that would 20th March 2020 issue precautionary measures like early closing times for public drinking areas; the disinfection of public marketplaces; the encouragement of employees to work from home; the restriction of non-essential domestic travel and constrained hospital visits by family and friends.

With the cases increasing in number, the Kenyan government restricted movement, imposed limitations on gatherings, issued a mask mandate in public, leading to a full lockdown. This spared food production, essential health and security services and food retail with some restrictions. The government cancelled all international meetings and centres, international flights into and out of the country and closed the borders to reign in on transmission. Cargo travel was allowed subject to a Corona test before entry. Domestic travel was restricted between major cities where infection rates were high. Schools and higher educational institutions, places of worship and social gatherings and prison populations were subjected to restrictions to avoid cluster outbreaks (Garda 2020).

The government used this period to expand testing capacity and the capability to locally manufacture personal protective equipment and other necessary supplies. It then relaxed the restrictions gradually as the incidence and death rates declined. Constraints related to inadequate finances to expand testing, increase the supply of personal protective equipment, and grow the capacity of hospitals. These measures coincided with a terrible locust infestation causing a major humanitarian disaster for people's livelihoods and commercial agriculture in Kenya and other neighbouring countries. The lockdown also hampered efforts to fight swamps of desert locusts by cutting or limiting access to some essential supplies like pesticides (Center for Policy Impact 2020; Kleinfield 2020). In partnership with Google, the Kenyan government launched a network of giant internet-enabled balloons to deliver emergency Internet across the country, a capacity that

was also used to spread information and to enable e-learning, working from home, and fostered e-commerce even in rural areas. Special measures had to be instituted to deal with the frequent movement of people between Kenya and its neighbours through targeted information, ambulatory health services and contact tracing across borders (Wangari et al. 2021).

The state response in Kenya was generally accepted and followed by the population, but the poor who had their back against the world could not fully comply with restrictions on their movement. The idea that they could die from hunger while avoiding dying from Covid infection epitomised the dilemma facing the destitute Africans all over the continent. Yet, the public approval of strict measures against Covid-19 was high throughout 2020. One survey reported that '80% approved of the way the government responded to the COVID-19 outbreak, with 49% strongly approving, and only 15% disagreeing with the government's approach. 82% stated that they trust the government to make the right decisions in the future' (Kantar 2020). Another survey later from a larger sample found that the majority of Kenyans (at 61%) trusted and were satisfied with the government response (Ipsos 2020). This was so despite the fact that a large number of respondents reported some loss of income and other financial difficulties.

Pundits regarded Senegal as exemplary in its response to COVID-19. The Foreign Policy's Covid-19 Global Response Index ranked the West African country second out of 36 countries. This was a judgement on the leadership shown by national leaders and government, clear and comprehensive public health communication and the mobilisation of capacities in society for a unified response to the epidemic (Chakamba 2020). The Senegalese state used capacities built during its response to the 2014 Ebola outbreak. For instance, the Health Emergency Operations Center that coordinates the operations of the public health response was set up for Ebola and played a critical role in overcoming that challenge. The format used to structure the political leadership in the response with the president and minister of health leading public health and political communication and mobilisation is similar to how the country managed the Ebola crisis.

Measures designed to limit transmission included dusk to dawn curfew, public gatherings were banned, domestic travel was restricted to essential travel, and international commercial flights were suspended. Places, where people gather in large numbers, were initially banned and later became subject to restrictions about the number of people who could be present in such venues at the same time. Schools and higher learning institutions were suspended and later became subject to restrictions. Again, this is following the WHO guidelines on Covid-19 with some lessons drawn from the Ebola outbreak six years earlier.

Rwanda is one of the countries that are said to have had a comprehensive response very early on in the pandemic (AfroWHO 2020a). In February 2020, a response plan was already in place, which was even before there was a single case of Coronavirus confirmed. Overall guidelines and detailed standard procedures were drafted as soon as news of the pandemic became known. Rwanda also set aside funds and raised further funds from other sources to finance its response as a mark of early preparedness. It set up systems for coordination with external agencies including donor and capacity building agencies to support the response. An advisory team including external actors to coordinate internal and external capacities seamlessly. A central treatment centre

was put up also in February and seventeen treatment centres were rolled out throughout the country within three months.

Rwanda immediately set up a National Joint Task Force made up of various areas of expertise including health, social services, logistics and so forth to coordinate a multi-sectoral response. The already centralised public information service was immediately immobilised to communicate the national response to the pandemic covering the whole country extensively.

Rwanda set up systems to offer Covid-19 testing before a single case had been confirmed and this was widely communicated to the population. Various testing sites were set up to offer 24 h 7 days a week. Testing was made available to everyone who needed and testers roamed the streets and randomly asked pedestrians, passengers of public transport and drivers if they needed testing. It shared the information fully with the World Health Organization (ibid).

Rwanda used its pre-existing capacity to efficiently managed major development projects, its ability to mobilise unity of purpose in the population and the state's ability to impose a direction for everyone in order to drive a comprehensive Covid response. President Kagame's strong hand drove an efficient implementation of the country's strategies and he demanded full accountability from authorities (Beaubien 2020). His leadership also meant limited opposition from the population as Rwanda was already used to the idea of putting national interests before other interests. This is how the country managed to test half a million suspected cases in the first five months.

Madagascar is one of the countries that had an early scare as the number of cases increased fast from late March, resulting in death also early. The numbers grew even stronger between July and August despite early responses to be briefly described. Advised by the WHO, the government imposed a state of health emergency that gave it some sweeping powers to undertake several actions. They quickly set up a risk-adjust response plan with a comprehensive reach. In no time, the government closed schools, suspended hospital visits, restricted local travel and banned international travel except for humanitarian, repatriation and cargo flights. There were restrictions on gatherings limiting them to no more than 50 persons for most of 2020. The country's public health response divided the country into 22 regions with customised strategies especially for 6 regions that remains badly affected to the end of the year. The aim was to stem the high levels of transmission between various parts of the island. The government imposed a mandatory 14-day quarantine for all with possible exposure to Covid-19 (Haider et al. 2020; Travaly and Mare 2020).

A lot of attention focused on the use of indigenous medicinal herbs found by some to be effective in treating Covid-19 cases. The idea caused much debate about the place and role of indigenous medical knowledge in the comprehensive strategy. These debates were internationalised by the government confidence in the specific industry indigenous herb, Artemisia annua. By 20 April, the government had had this herb produced in large numbers and the president became a major champion for its use. It was distributed in communities. The world health fraternity was thus forced to consider indigenous medicine. On 3 May 2020, the WHO released a press statement welcoming innovations in the fight against Covid-19 including the use of traditional medicine, but called for these products to be scientifically tested for efficacy and safety (AfroWHO 2020b). Ten days later the African Union's Africa Centre for Disease Control announced plans to

conduct the tests in indigenous medicines touted as treatments and preventive remedies (Tweet by Kwesi Quartey, African Union Commission, 13 May 2020). Madagascar started taking orders and making donations of the herb to other countries as well (Rajoelina 2020). Madagascar invested in a pharmaceutical plant, Pharmalagasy, for mass production of the herb and other treatments. It saw an opportunity for local production medicines the local population needed even in the long term. It also established a Laboratory for Medical Analyses to help Madagascar have independent medical supplies (Rajoelina 2020). The laboratory was to help increase the capacity to test for Covid-19.

Madagascar was critical of international pharmaceutical production value chains and the big corporations that are seen as reinforcing inequality and inequity in health access between the North and South. It linked the challenges the island faced accessing essential medicines and equipment to global power relations skewed to the disadvantage of Africa. The government in Antananarivo was irked by the scrutiny that the herb was put under, the kind of scepticism cast by some in the medical and pharmaceutical world the world over.

While all these countries profiled have followed the WHO guidelines and placed the state at the centre of Covid-19 response, in the process the impact of diminishing state capacity has become apparent. It has emerged across the board that countries in Africa lack the capacity to extend basic health care to the whole of society equitably. We have however known this for a while and have been warned to enhance health access in terms of basic public service. We have also been alerted to the long-term impact of diminished health governance generally and that this exposes Africa to the vagaries of global biopolitics (Zondi 2014). These research findings including the fact that Africa's health challenges nest in the failure of the state and development manifest in growing poverty and inequality in the 1980s to the 2000s. Globalisation, we were warned, is a key factor both in the cause (health determinants) and effect (current health status) in Africa (*Ibid*) Each of the countries referred to above put the state at the centre and this revealed capacity constraints in health services, social services and so forth.

Yet, we also noted the fact that the alternative to the state was not remarkable. Contrary to expectations that there was greater capacity in the private sector and NGO sector, no evidence was found that suggested that these non-state actors took over functions the state battled to discharge fully. The capacity of the business and NGO sectors also need beefing up. In all cases, these two sectors played crucial roles in supplementing government efforts. In all these cases, attempts were made by the state to strengthen a social compact between the state and non-state actors. Strong statements inviting the business sector were evident in Kenya, Senegal, Madagascar and Rwanda. Rwanda strongly solicited the assistance of small businesses in assisting the public health response including in the local manufacturing of PPEs and the preparation of local health centres all over the country. While governments invited civil society to join hands with the government and private sector in these undertakings, it seems that there is no specific responsibility placed upon NGOs and so forth. These organisations end up being limited to the provision of humanitarian relief to the destitute to the extent they are able to.

The story in the period since the 1980s has been about donors redirecting some social spending to the NGOs as a result of mistrust of government and diminished state capacity due to structural adjustment programmes and neglect. But during the Covid-19 pandemic, we have seen donors redirect funding back to the state, somehow recognising

that the state has the legitimacy and national reach to ensure equitable distribution of means and support. However, this shift happened amid the pandemic rather than in the decades prior where it might have helped to build institutions and capacities African countries needed to cope with and fight the disease.

Worse, the shift in focus and spending to the state weakened the civil society sectors as funding and support nearly dried up at the time when they were elected to upscale their programmes. NGOs found themselves battling the mismatch between heightened expectations and diminished resources (Nsengiyumva 2020). In the case of Rwanda the strong state, business and civil society compact established under the National Strategy Transformation in 2018 were crucial in response to COVID-19 but resources were insufficient to give full effect to this three-way partnership (*ibid*, p.10). Kenya reported a growing number of civil society initiatives at the local level mobilising vulnerable people to seek public health opportunities, support one another and combat the rise of Gender-Based Violence that spiked during the crisis. The formations had to survive massive constraints to their funding and support as they were donor-focused on the state (Sarungi-Tsehai, Mugambi, and Farisani 2020).

Conclusion

This is a preliminary analysis based on secondary and primary documentary data. It is designed to frame a response to the question posed at the beginning, about whether there has been a return of the state in public policy in country responses to Covid-19 in 2020. This is largely based on the insight gained in the first part of 2020 when new measures had to be imposed and the measures were generally the same to make it easier to identify patterns across countries. A few countries are chosen with the hope that together they generate insights needed to frame a response to our research question. The discussion shows that there are indications that the state played a central role in driving the public policy response to the health crisis. and that in the process it has either experienced growth of public trust in it or it has not diminished. In this the state has responded to the WHO guidelines that place the state at the centre of country responses to the Covid-19 calamity. The state has seised the opportunity to brush up its image in the eyes of the public by capitalising on the crisis to showcase its capabilities. The state has generally harnessed the capacities that pre-exist the crisis and developed new ones in some cases to play this central role. So, indeed, on account of the evidence from 2020, the state is back at the centre of society's responses to crises. But whether this will be sustained beyond the Covid crisis is a subject for conjecture.

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