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Public Health practitioners must understand the role of power in a pandemic because it significantly influences the formulation and implementation of public health policies. The COVID-19 pandemic has demonstrated this phenomenon so well.

Coronavirus disease 2019 (COVID-19) was first identified amid an outbreak of respiratory illness cases in Wuhan City, Hubei Province, China. It was initially reported to the World Health Organization (WHO) on December 31, 2019. On January 30, 2020, the WHO declared the COVID-19 outbreak a global health emergency and on March 11, 2020, a global pandemic. Since then, the virus has spread globally, infecting [5,596,550 people and causing 353,373 reported deaths as at 28th May 2020](#).

Public Health is concerned with the health of a population and is defined as “the science and art of preventing disease, prolonging life and promoting, protecting and improving health through the organized efforts of society”. Inherent in the practice of public health is how society organizes itself which involves the issue of governance and its associated distribution of power. The health sector has always been seen by many as a huge source of expenditure while others see it as a huge economy through the businesses of pharmaceutical companies and biomedical technologies. These perceptions generate many actors and conflicting decisions. Although health policy refers to the decisions taken or not taken by those with responsibility for a particular policy area, we should remember that policymaking is a struggle between groups with competing interest. Hence, the outcome of any conflict depends on the balance of power between the individuals and groups involved, and roles and processes or rules established to resolve those conflicts. For us to understand the decisions among countries and policy actors in the COVID-19 pandemic, we need to understand the nature of power, how it is distributed and the manner through which it is exercised.

For the purpose of a general discussion and analysis of the nature and expression of power, its distribution and how it is exercised in COVID-19 policy making, we will draw on [John Gaventa's](#) power cube framework. He conceptualizes ‘three dimensions’ of power as the spaces, forms and levels of power. These dimensions are conceptualized using a cube with each dimension representing one side of the cube. There are three components within each dimension.

Power can be exerted at the global, national and local levels. ‘Spaces’ are seen as opportunities, moments and channels where citizens can act to potentially affect policies, discourses, decisions and relationships that affect their lives and interests. The spaces available for taking part in decision making are classified into closed, invited and created. In *closed spaces*, decisions are made by a set of actors behind closed doors, without any pretence of broadening the boundaries for inclusion. In *invited spaces*, people (citizens or beneficiaries) are

invited to participate. *Created spaces* are the spaces which are claimed by less powerful actors from or against the power holders. Created spaces may come into being as a result of the popular mobilisation of less powerful actors around identity or issue-based concerns or may consist of spaces in which like-minded people join together in common pursuits.

The forms of power are classified into *visible, hidden and invisible*. Visible power is the justified decision making which includes the visible and definable aspects of power – the formal rules, structures, authorities, institutions and procedures of decision making. *Hidden power* is the process involved in setting the political agenda. Certain powerful people and institutions maintain their influence by controlling who gets to the decision-making table and what gets on the agenda. Invisible power is shaping meaning and what is acceptable. This is probably the most insidious of the three dimensions of power, invisible power shapes the psychological and ideological boundaries of participation. By influencing how individuals think about their place in the world, this level of power shapes people's beliefs, sense of self and acceptance of the status quo.

Applying the above-mentioned framework to analyse the power dynamics displayed in the policy formulation and implementation in COVID-19 pandemic is interesting. At the Global level, it was believed that China did not invite other countries into their decision space in the early aspects of the pandemic. They used the closed form of power to manage the decision space. This assertion has generated political feud between the USA and China. Though the deliberations in the pandemic started as hidden and invisible forms of power in which people's belief systems were influenced through conspiracy theories, this influenced the policy formulation and implementation of travel restrictions to China. The established institutions like the United Nations (UN) and WHO introduced visible power into the management of the policies and eventually, the belief that it was a Chinese disease fizzled out, though some aspects of the belief about the origin of the virus lingered on.

In April and May 2020, more invited spaces of power in decision making were justified by the world. United Nations' Secretary-General [Antonio Guterres](#) called upon the G-20 to move ahead with a special Africa initiative and appealed to developed countries to support the health systems and response capacity in lower-income nations. Otherwise, we will be faced with the nightmare of the disease spreading 'like wildfire' resulting in millions of deaths and the prospect of the disease re-emerging where it was previously suppressed. Another reason that was given was the economic fallout that the outbreak could trigger and the associated recession of unprecedented scale. It was estimated that up to [24.7 million jobs could be lost globally, reducing GDP growth by around 8 per cent](#). The fear of many more deaths and economics were contextual factors that altered the power structure of decision making in favor of the inclusion of many more countries. The UN General Assembly approved a resolution to hasten the "rapid development, manufacturing and distribution of diagnostics, anti-viral medicines, personal protective equipment (PPEs) and vaccines" needed to fight the COVID-19 pandemic. This resolution was co-sponsored by about 170 countries and gave power to the UN Secretary-General Antonio Guterres to work with the World Health Organization "to identify and recommend options" to [ensure timely and equitable access to testing, medical supplies, drugs and future coronavirus vaccines for all in need, especially in developing countries](#).

The resolution was welcomed by a number of bio-pharma and medical technology industry associations by emphasizing their support for more international collaboration in the quest for treatments. The resolution also reaffirmed the fundamental role of the United Nations system in coordinating the global response to control and contain the spread of COVID-19. The 193 U.N. member states, acknowledged the crucial leading role played by the World Health Organization. Luckily, the United States did not use its power to block the adoption of the text, despite the fact that the U.S. President Donald Trump had suspended funding to the World Health Organization. He accused WHO of failing to alert member states about potential human-to-human transmission early enough and wrongly opposing travel restrictions. As the pandemic progressed, more actors were invited

into the decision arena at the global level and the power is more broadly distributed now.

At the national level, many countries' decisions to lockdown and impose travel restrictions were done behind closed doors and so some of the announcements came as a surprise to their citizens. Many citizens complied initially because of the perceived fear of the illness but after some days and weeks of lockdown some citizens claimed power and revolted. It was believed that aside the economic hardships individuals faced, opposition political parties used invisible power to influence some of the citizens to revolt by galvanizing them around the ideas of incompetence and insensitivity of ruling parties. These displays of citizens power forced the leaders of many countries to lift the restrictions. Many governments were also forced to release bailout packages to enable companies to pay their workers after workers' unions and the media started discussing the issues concerning the loss of jobs due to the pandemic.

Like many countries, Ghana has experienced similar trends in the distribution and use of power to influence its health policies since 12th March 2020 when the first case of COVID-19 was reported. As at 28th May 2020, Ghana had recorded [7,303 cases with 34 deaths](#). The Ghana Health Service, Public Health Experts, Teaching Hospitals, Research Institutions, Universities, Non-Governmental Organizations, business groups and various ministries have worked closely with the presidency to influence, formulate and implement policies in the pandemic. In spite of these stakeholder's involvement in the decision-making process, many people think the Government and some institutions are using closed power. The three-week partial lockdown and other restrictions came as a surprise to many citizens, so the military and the police assisted in the enforcement and implementation of some of the policies. The partial lockdown was lifted when citizens appealed to Government on grounds of socioeconomic hardships. The cases continue to rise though restrictions on social gathering are still in force. Many groups are advocating for the reopening of schools and churches. They are using claimed, hidden and invisible power to achieve their objectives. Many other groups are opposing this because they assume that deaths may rise when the ban on social gatherings are lifted. Interestingly all the groups are claiming to be using "science" as the basis of their advocacies. The Government decision will be a result of the balance of the influence of power the groups bring to bear in these deliberations.

At the local level, District Health Systems and District Assemblies are struggling to implement local policies of social distancing, wearing of mask, handwashing, the use of sanitizers, isolation and quarantining infected people with varying difficulties in the midst of the use of power by various citizens and groups. The success of the various interventions to curb the spread of the virus depends on how well these institutions exercise their power in the communities.

In conclusion, Public Health practitioners must appreciate the fact that power is widely distributed in society and the health policy process involves the exercise of power by competing actors and the manner in which these struggles are resolved depends to a large extent on who has power in the society.