International Journal of Law in Context (2021), **17**, 249–260
doi:10.1017/S1744552321000318

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ARTICLE

Indicators, security and sovereignty during COVID-19 in the Global South

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Abstract

The spread of COVID-19 has seen a contest over health governance and sovereignty in Global South states, with a focus on two radically distinct modes: (1) indicators and metrics and (2) securitisation. Indicators have been a vehicle for the government of states through the external imposition and internal self-application of standards and benchmarks. Securitisation refers to the calling-into-being of emergencies in the face of existential threats to the nation. This paper contextualises both historically with reference to the trajectory of Global South states in the decades after decolonisation, which saw the rise and decline of Third-World solidarity and its replacement by neoliberalism and global governance mechanisms in health, as in other sectors. The interaction between these modes and their relative prominence during COVID-19 is studied through a brief case-study of developments in Kenya during the early months of the pandemic. The paper closes with suggestions for further research and a reflection on parallel trends within Global North states.

Keywords: health governance; sovereignty; Global South; Kenya; securitisation; COVID-19

1 Introduction

The spread of COVID-19 has been a telling moment or *épreuve* in contests over governance in Global South states.[1] Two distinct governance modes are engaged in this crisis: (1) indicators (and metrics) and (2) securitisation. Indicators have been a vehicle for the government of states, particularly in the Global South, through the external imposition and internal self-application of standards and benchmarks, and through the comparative rankings that ensue therefrom. Securitisation refers to the performative calling-into-being of emergencies in the face of designated existential threats. Both modes have been on display and subject to challenge during the COVID-19 pandemic. National sovereignty is at stake in both: limited, superintended and redirected by indicators on the one hand; articulated as originary and untrammelled through securitising moves on the other. Health has been a key focus for analysts of each. Stopping the spread of disease is cast by scholars as a pre-eminent task for 'the international community', with post-colonial, Global South states figured either as useful transmission belts or as obstacles, recalcitrant and corrupt (Gostin, 2014).[2] Contrariwise, the nation has been taken by political leaders and citizens around the world as the primary object of the pandemic threat and the central agent in responding to it. Solidarity has been defined in national terms; vaccine development and roll-out have been framed as a competition between nations. Geostrategic contests, most notably between China and the US, but also between the UK and its former EU partners, have been similarly denominated.

We may hypothesise that COVID-19 is the occasion for an as-yet undecided contest between de-spatialised health governmentality and the reassertion of territorial segmentation as the frame

[1]See Boltanski and Chiapello (1999).
[2]See also Harrington (2020b).

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https://doi.org/10.1017/S1744552321000318 Published online by Cambridge University Press

for an autochthonously defined national interest – a retreat, it is feared, from Post-Westphalian to Westphalian governance in global health (Fidler, 2020). The lineaments of this struggle can be presented more clearly through a discrete focus on indicators and securitisation, and the interplay between them. In what follows, I first sketch an outline of each governance mode, remarking on the application of each to health promotion in the Global South. The purchase of this theoretical outline is then tested briefly through a focus on Kenya and, in particular, its response to COVID-19 in the early months of the pandemic, between February and May 2020. Both modes were deployed in political and legal interventions during this period. It is clear that government ministers tended to adopt securitisation language, while foreign and civil-society actors drew on indicators and related benchmarks to support criticism of state action and inaction. In conclusion, I also reflect briefly on the extent to which these tendencies hold true for Global North, as well as Global South states and the significance of this for the future of global health governance.

2 Indicators and metrics in global health

I focus here not so much on the production of indicators, as on their use. In this regard, socio-legal studies, such as the work of Sally Engle Merry, have clear affinities with the critique of metrics in global health developed by medical anthropologists such as Vincanne Adams (Adams, 2016; Merry, 2016).[3] Both note the depoliticising intent behind indicators, which are to provide neutral representations, permitting objective judgment (Davis *et al.*, 2012, p. 76). Both point to a distinct theory or worldview underpinning these technologies. Repeated use sustains these effects by 'hardening' indicators into common sense, as they are taken up by more or less powerful actors in a given field, such as health policy. Equally, contestation may undermine their pragmatic effectiveness by laying bare the contingency of their production.[4] The stability and power of indicators, or loss of the same, are thus achieved 'in action', as Siems and Nelken (2017) put it.

In focusing on the Global South, we do well to take account of the 'globality critique' raised in this context by Morag Goodwin (2017). Attention must be paid to the specific cultural and political contexts within which particular indicators see action. Such discrete 'rhetorical situations' certainly include international sites, like the World Health Organization (WHO) or the UN General Assembly, at which global health governance is produced and debated.[5] But they also arise in regional, national and local fora, whether formal or informal, where measures are translated, transformed and resisted. This should lead further to a genealogical concern with the colonial origins of 'indicator culture' (Merry, 2016, pp. 9–20). Europe's colonies and the independent states that succeeded them have been defined, privatively, as uncivilised, insanitary and underdeveloped (Escobar, 1995). Indicators mark that backwardness, as well as the progress of territories and peoples away from it, ranking them over time and relative to each other.[6]

This is not an undifferentiated history of tutelage. Until the end of the 1970s, Global South states asserted strong sovereignty against former colonial powers and monopoly capital through demands for a New International Economic Order. In the present context, they were accorded a leading role in realising the WHO/ UNICEF Declaration of Alma Ata on 'health for all'.[7] Adams characterises that phase as one of 'inter-national health' (Adams, 2016, p. 6). This was moreover an era in which health statistics were also produced and deployed, but largely by and only within nation states themselves, rather than as part of a more dispersed, externally driven governance system (Fisher and Fukuda-Parr, 2019, p. 375). The dream of a strong health state endures, as we will see in the next section.[8] But its

[3]As well as the affinities discussed in the text, both authors adopt a normative–methodological stance in defence of qualitative, ethnographic research as an inclusive source of evidence to complement and counter the ascendant quantitative mode.

[4]For a fine example, see Oni-Orisan (2016).

[5]See Bitzer (1968); Merry (2006).

[6]See generally Davis *et al.* (2012).

[7]See Chorev (2012).

[8]See further Geissler (2015).

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realisation was sharply curbed in the 1980s as a result of economic shocks, structural adjustment and the collapse of the bipolar Cold-War order. States were disciplined first by technologies of economic governance and then, more widely, through the elaboration of detailed health and other social targets (e.g. on child nutrition and immunisation), and their enforcement via aid conditionalities (Tan, 2011).

Metrics met and meet a concern with health outcomes as well as inputs, and with the causal connection between them.[9] They enable the framing of accountability in quantitative and value-for-money terms, thus enabling an ongoing commercial and philanthropic takeover of aid delivery in this field (Erikson, 2016). Indeed, the development of indicators has itself been privatised, with commercial and non-governmental bodies leading in their production: Transparency International's Corruption Perception Index is perhaps the most notable example (Fisher and Fukuda-Parr, 2019, p. 376). UN bodies have followed, with indicators giving concrete and measurable detail to states' right to health obligations under the International Covenant on Economic Social and Cultural Rights, for instance (Merry, 2016). Similarly, the WHO's International Health Regulations (IHR) were comprehensively revised in 2005, moving away from their minimalist, state-led approach to disease control (Fidler and Gostin, 2006). National authorities lost their exclusive power to notify the WHO of disease outbreaks – that is, official concealment can now be circumvented by scientists and non-governmental organisations, as demonstrated during the 2003 SARS outbreak in China (Fidler, 2003). In practice, this outflanking of the state's informational monopoly had already been achieved with the creation of the online Global Public Health Intelligence Network (GPHIN) and the Global Outbreak Alert Response Network (GOARN) by Public Health Canada and the WHO, respectively, in the late 1990s, which allow 'real-time' gathering of outbreak intelligence from any source around the world (Wenham, 2015). The IHR also require states to maintain institutional capacity to detect epidemics and to put in place statutory measures to enable a proportionate response, or what has been called 'public health emergency legal preparedness' (Murphy and Whitty, 2009). States' efforts to meet the latter set of obligations are monitored by a Joint External Evaluation, superintended by the WHO, which offers technical advice (Boyd *et al.*, 2020). Pandemic preparedness is also the subject of the Global Health Security Index (GHSI) prepared by the Johns Hopkins Center for Health Security, the Nuclear Threat Initiative and the Economist Intelligence Unit (Abbey *et al.*, 2020). This ranks states according to combined evaluation of their capacity inter alia for prevention, detection and rapid response, as well as health-system robustness and commitment to international disease-control norms.

The most recent era, that in which COVID-19 appeared, is one of 'global health', marked by a normative and institutional reorientation of the state apparatus (e.g. constitutionalisation of human rights, creation of parastatals to collect data and implement feedback) and an empowering of other domestic and foreign actors (e.g. the judiciary, civil society, donor agencies) to police states' performance (Adams, 2016; Harrington, 2021). The depoliticising effect here involves an occlusion of the neo-imperial reach of this regime behind techniques of counting and ranking. The underlying worldview is an alloy of humanitarianism, new public management and an older developmentalism (Lakoff, 2012). To return to Adams, indicators and metrics, and related governance technologies, instantiate a 'new kind of sovereign' beyond the nation, whereby the state is interpellated as the subject responsible for the promotion of its citizens' health and called to account at multiple instances (Adams, 2016; Hardt and Negri, 2000).

3 Securitisation and infectious disease

A rival view of health sovereignty is suggested by the Copenhagen School of security studies (Buzan *et al.*, 1998). At the centre of that analytic are moments of 'securitisation' that achieve the suspension of normal politics in time of emergency and its replacement by special measures. A successful securitising move involves the identification of an existential threat to a significant referent object in a form

[9]See the contribution by Siems in this issue.

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consistent with relevant linguistic conventions. Such moves are illocutionary in that they are per se performative of the shift from normal to special.[10] The suspension of normal politics in this way represents a primordial exercise of sovereignty consistent with Hobbesian and Schmittian views of the state (Williams, 2003). This is not to say that all rules and guarantees *are* automatically suspended on foot of a securitising move, but that they *could be*, and that the sovereign is definitively the locus of the decision to do so. It is true that securitising moves are made at an international level, in terms of global health crises, such as UN Security Council resolutions to the effect that HIV/AIDS and Ebola, respectively, were threats to international peace and security (Harman and Wenham, 2018; Rushton, 2010). Nonetheless, these are considerably less frequent, and arguably less persuasive, than those framed in national terms. By contrast with the sphere of indicators discussed above, here the 'global health sovereign' is in the background.

Subsequent writers have extended the category of 'referent objects' capable of being securitised beyond territorial integrity and military security to include population health (McInnes and Rushton, 2012). Pandemics can clearly be represented as existential threats to health, but also to economic and political stability (Curley and Herington, 2017). The relevant formalities for the securitising move may be found in law, such as permissible derogations from human rights in national constitutions or, at the international level, the WHO's power to declare a 'Public Health Emergency of International Concern' (Gostin, 2014). But these legal forms do not exhaust the political possibilities.

Other work has challenged and revised significant elements of the Copenhagen School model in ways relevant to the current discussion. By limiting securitisation to well-defined and self-contained speech acts, it overlooks the role of audience engagement in the success or failure of any given move. The latter, thus, depends on a more wide-ranging persuasive (or 'perlocutionary') effort (Balzacq, 2005; Perelman, 2000). In the case of pandemics, that often involves evoking an atmosphere of dread and horror (Stern, 2002). Specific colonial histories and post-colonial concerns may add resonance, too. For example, Indonesia's decision to withhold virus samples from the WHO during the 2006 H5N1 outbreak followed on a securitisation of national resources and the threat to them of expropriation by foreign vaccine producers, summarised as an assertion of 'viral sovereignty' (Hameiri, 2014). Securitisation, then, is better viewed as a process than a moment, and as a continuum rather than a binary outcome. It may fail or succeed partially only (Rushton, 2010). Speech and text matter, but so too do images and actions, which may prefigure or contribute to verbal securitisation moves, as where police enforce a lockdown in advance of a presidential declaration (Wilkinson, 2007).

The normatively Eurocentric nature of securitisation theory also leads it to presume a unified nation with uncontested interests, capable of being existentially threatened, and to posit a sharp distinction between normal and special politics (Vuori, 2008). Experience in the Global South has been more varied. Post-colonial states and their interests are less coherent than the model suggests, not least due to the impositions of global governmentality discussed in the previous section. Moreover, colonial and independence regimes have long subsisted with the help of wide executive discretion and open-ended emergency legislation creating (semi-)permanent states of exception (Simpson, 2004). The line between the normal and special is fluid. To return to Goodwin's 'globality critique', noted above, the form and outcome of a securitising move can, thus, only be grasped by paying careful attention to its historical, cultural and institutional context. In the following sections, I pursue this insight briefly, with reference to developments in Kenya in the early months of the coronavirus pandemic.

4 COVID-19 in Kenya: indicators and securitisation

4.1 Timeline – February to May 2020

Measures taken in Kenya in anticipation of, and in response to, the spread of COVID-19 were marked by considerable and relatively indiscriminate coercion. On 13 March, the first case was confirmed in a twenty-seven-year-old woman who returned to Kenya from the US via London (Merab, 2020).

[10]See Austin (2005).

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The following day, the government banned all public events (Anon, 2020a). By 15 March, three more cases had been discovered and President Uhuru Kenyatta unveiled a range of measures to combat the spread of the virus, encouraging people to work from home and to practise hygienic measures (Ministry of Health, 2020). On 22 March, the government stopped all international flights (Tanui, 2020). Three days later, a 7pm to 5am curfew was announced. Although a range of fiscal measures to help mitigate the economic impact of these steps was also announced, they did little to offset the impediments posed to Kenyans working in the informal sector, particularly women and those living in slum settlements. Police enforced the curfew indiscriminately and with considerable violence, causing serious injuries to many, with at least one fatality. This triggered protests from local and international human rights organisations and the launch of a constitutional challenge in the Nairobi High Court (Wambui, 2020). In April, travel in and out of Kenya's two largest cities, Nairobi and Mombasa, was restricted and the Cabinet Secretary for Health made it mandatory to wear face masks in public (Anon, 2020b). Despite these measures, which remain in force, the number of coronavirus cases continued to rise through the period discussed. By the end of May 2020, Kenya had a total of 1,962 confirmed cases with sixty-four people recorded as having died of the virus (WHO, 2020).

4.2 Indicators in use

Within Kenya, there was considerable criticism of these measures for their lack of a rational basis and design articulated using the technologies and idiom of global governmentality set out above. For example, two Kenyan epidemiologists complained respectively about the government's lack of transparency in relation to data-sharing protocols, which would allow the disease to be tracked, and its failure to specify 'a scientifically determined threshold on when lockdown measures could be relaxed' (Nanyingi, 2020). However, indicators, and metrics specifically, played a relatively small role in internal discussion of the response to COVID-19. Most prominent in the earliest phase of the pandemic was an index of preparedness and vulnerability among African countries published in *The Lancet* on 20 February by Gilbert and Pullano (2020). This paper modelled the potential impact based on multivariate analysis of existing indicators, primarily the WHO's IHR Monitoring and Evaluation Framework, which is itself a composite of both self-assessment, annual reporting data, external evaluations, after-action reviews and simulation exercises. It also drew on the Infectious Disease Vulnerability Index, which helped to account for 'indirect factors that might compromise the control of emerging epidemics, such as demographic, environmental, socioeconomic, and political conditions' (Gilbert and Pullano, 2020, p. 873). These data were mapped alongside the volume of air travel in the country to estimate the risk of importation.

The Gilbert index was picked up by commentators in the Global North as an early call for action to support African health systems, but also to highlight the potentially catastrophic results of the virus spreading to the continent. A further paper in *The Lancet* used it to highlight the need to 'act collectively and fast', arguing that the authors had provided a valuable tool to help countries 'prioritise and allocate resources' (Nkengasong and Mankoula, 2020). This theme was given more sensationalist expression in media headlines and stories, which relied on the index to claim that 'the outbreak could become uncontrollable if it reaches densely populated African mega-cities' (Newey, 2020) and that a 'potential calamity' awaited without 'increased [external] resources and surveillance of vulnerable African nations' (Humphreys, 2020).

Kenya was ranked as a 'medium-risk' country on the Gilbert index owing to its 'variable capacity' to deal with the pandemic and its 'high vulnerability' (Gilbert and Pullano, 2020, p. 873). This categorisation gained salience with the controversy over a flight from China that landed at Nairobi airport carrying 239 passengers in late February 2020 before border restrictions were introduced. A video of the flight posted on social media triggered outcry, though the government insisted that flights were safe and that international guidelines had been adhered to (Kahura, 2020). Intervening in the debate, prominent journalist Patrick Gathara relied on the index to criticise the government's preparations. 'While Kenya had a moderate risk of importing the virus from China,' he wrote, 'it had amongst

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the lowest scores on the continent for the capacity to handle an outbreak' (Gathara, 2020). The authorities needed to increase public information and to prepare people and the health-care system for the effects of the pandemic. At that point already, Gathara argued that to stop flights into Kenya was a distraction, suggesting that the virus would come to the country eventually and it was better to prepare for it. By contrast, Kenya's most widely read newspaper, the *Daily Nation*, alluded to a University of Southampton study that, it claimed, ranked Nairobi as 'sixth among African cities whose populations are at high risk of being infected with Covid-19' while 'government bureaucrats continue[d] to allow in travellers from eighteen high-risk cities in mainland China' (Kamau and Achuka, 2020). Ultimately, the Law Society of Kenya successfully petitioned the high court to force the government to suspend flights from China, basing its claim on the then current WHO list of 'hotspot' countries (WHO, 2020). The Gilbert index was also picked up on Twitter by Kenyans critical of government inaction.[11] Beyond these instances, we have found little evidence that indicators were deployed by either the government or its critics in this period.

4.3 Securitising moves

In contrast to the relatively low frequency of indicators and metrics in domestic debate, a review of political speeches, legal interventions and relevant media from this period shows the prominence of securitisation discourse in the sense used by the Copenhagen School. The president thus referred repeatedly and dramatically to the 'extraordinary' and 'emergency nature' of COVID-19 claiming that 'our national interest [has never] been threatened to this extent before' (Kenyatta, 2020a). 'Our families,' he declared, 'our schools, our way of life, the way we worship, our economy, our businesses, our workers, every single Kenyan stands threatened by this invisible, relentless enemy.' The struggle against the virus was a 'war' in which the Kenyan people were called to fight (Kenyatta, 2020b). In this vein, steps to secure the border 'against security threats' and the imposition of lockdown measures in refugee camps served to associate COVID-19 with the ongoing threat of terrorist incursion from Somalia (Mwangi, 2019). Evoking previous pandemics, such as sleeping sickness in colonial East Africa, and his own role as commander-in-chief, Kenyatta pledged to 'do everything in [his] power to ensure that we, as a nation, shall not suffer such terrifying outcomes' (Kenyatta, 2020b). The ambition to suspend normal politics, which is the result of successful securitisation, was suggested, ironically, by the government's refusal to declare a state of emergency formally under Article 52 of Kenya's 'reform' Constitution of 2010, which would have subjected these measures to procedural and human rights constraints (Kabira and Kibugi, 2020). Rather, use was made throughout of presidential decrees, without statutory basis, to announce disease-control measures and of the broadly framed Public Order Act, rather than the dedicated Public Health Act, as the basis for enforcing them. The latter step was upheld by the Nairobi High Court on the basis that 'panic and fear' might lead to extensive disorder requiring more than health-based measures in response.[12] The authoritarian tone was amplified in media commentary, which noted that China's speedy reaction had been enabled by 'a decisional process … unencumbered by layers of bureaucracy and government … powers to enforce its measures from the top down' (Chagema, 2020). The Chinese response is figured here as one that prioritises effectiveness and efficiency over politics, in a similar manner, ironically, to the global health and governance indicators discussed above that emanate largely from Europe and North America. This approval may also be informed implicitly by a sense of anti-colonial solidarity – a theme that has featured prominently on the Chinese side in subsequent promises to donate vaccines to African states (Biegon, 2020).

The president's speeches implied that the audience for the government's securitising move was the whole citizenry. Code-switching between English (global, colonial) and Kiswahili (national vernacular and official language), he prophesied that 'Our nation shall prevail, the aspirations of our destiny shall

[11]See e.g. Ongwae (2020); Okioma (2020); Mabonga (2020); KOT (2020).

[12]*Law Society of Kenya v. Hillary Mutyambai* (High Court of Kenya at Nairobi per Korir J. at para. 113) *eKLR* 2020.

https://doi.org/10.1017/S1744552321000318 Published online by Cambridge University Press

stand. Together we shall be victorious. *Pamoja tutashinda*. We can and we shall defeat the Coronavirus Pandemic' (Kenyatta, 2020a). This familiar mode of constituting an affirmative identity shared between speaker and hearers was undercut by the more coercive and accusatory rhetoric of the Cabinet Secretary for Health, Mutahi Kagwe (Agutu, 2020). Emphasising the need for discipline, he focused on violations of sanitary rules on public transport, such as expressing

> 'disappointment with Boda Boda [motorbike taxi] operators who, despite our repeated advice, are carrying more than one passenger at a time… this is not the time for cat and mouse games. If it gets to that level of disobedience, we will have no choice but to deploy stiffer measures against you.' (Kagwe, 2020)

He condemned 'young people who deliberately break curfew regulations due to the false belief that they cannot catch this disease' (Kagwe, 2020). Kagwe urged citizens to 'point out those in our midst who are not observing the measures, thereby putting our nation at great risk' – a group described in media commentary as 'traitors' who belonged 'in the lowest circle of Hell with Judas Iscariot' (Kagwe, 2020). This impetus to exclude and condemn enemies of the people was bolstered by the (in fact wholly counterproductive) use of quarantine, originally intended for new arrivals from abroad, as a punishment for Kenyans violating disease-control measures (Human Rights Watch, 2020).

4.4 COVID-19 and the ideology of order

The foregoing bears out several features noted in critiques of securitisation theory, especially as it applies in Global South contexts. First, we observe that the securitising move is the result of an iterative process over a period of months, rather than a one-off speech act. Successive interventions complement each other by emphasising different elements of the Copenhagen School formula. Law matters in this, but more by way of non-steps (i.e. failure to make a constitutional declaration of emergency) and formal technical choices (i.e. as between types of legislation and in favour of decrees) than through the direct assumption of powers. In addition, we saw that coercive action did not flow mutely from antecedent verbal moves. Rather, it also preceded statements, contributing itself to their securitising effect by creating an atmosphere of emergency. None of this happened in a historical vacuum. Presidential and ministerial statements explicitly or implicitly evoked *lieux mémoires* of Kenyan history, such as colonial depredations, the war against the Somali minority and the related terrorist threat. More insidiously, the mode of address alternated between a bland inclusivity and an authoritarian call to discipline (Choto, 2020). Reinforced by police and state paramilitary deployments, these evocations again reproduced the 'ideology of order' that has oriented the practice and self-image of the Kenyan state since its inception, according to E.S. Atieno-Odhiambo. Anxious about territorial fragmentation and ethnic conflict, elites have insisted 'at all times that sovereignty, national unity and national security are sacred and inviolate' (Atieno-Odhiambo, 1987, p. 187). As Makau Mutua has argued, this is an essentially Hobbesian vision of the state as prior to and above normative entanglements, centralised and self-sufficient (Mutua, 2008). Serious attempts have, of course, been made to tame the Kenyan Leviathan, such as by entrenching fundamental rights and subordinating the legal order to global governmentality regimes, including indicators and metrics, as discussed above. But the ideology of order and related coercive routines remains to hand as a reflex response in times of political breakdown (e.g. disputed elections) (Harrington and Manji, 2015), security crises (e.g. terrorist attacks) (Harrington, 2020a) and, now, pandemic outbreak.

5 Conclusion and a coda

The greater and lesser prominence of 'securitisation' and 'indicator culture', respectively, in Kenya in the early months of the COVID-19 pandemic suggests a moment in which the governmentality network of global health was eclipsed by a more forthright exercise of national sovereignty as regards

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disease control. However, this is only a limited conclusion. Further investigation will be required covering the subsequent career of the (unfortunately) ongoing pandemic. Attention also needs to be paid to the continued vigour (or not) of other elements in the ensemble of globalised health governance, including litigation based on UN human rights norms, for example. It is too early to draw broad definitive conclusions about 'the return of the nation state' in global health or otherwise. Further investigation would also be required on the extent to which indicators partake of *both* global governmentality *and* securitisation. Thus, indicators were used by foreign observers to make catastrophic predictions regarding the spread of COVID-19 in Africa as a whole. This runs together the mode of government by numbers with a longer established idiom of the continent as an exceptional space of infection.[13] It evokes dread and tends to counsel defensive self-isolation on the part of northern states.

More specifically, we saw above that Kenyan commentators used indicators to criticise and (it was hoped) constrain the unscientific action and inaction of the authorities. This may be an instance of indicators being used not instead of securitisation, but as a means of conditioning its application. This possibility would be consistent with Clare Wenham's recent critique of global health security. She argues that the 'securitization of health', much discussed by writers following the Copenhagen School, is increasingly matched by a 'healthification of security' (Wenham, 2019, p. 1102). The latter refers to the designation as security threats of health factors that are more routine and less apparently urgent than infectious disease, such as the lack of universally accessible health care in a given territory. Wenham argues that this in turn demands a more precise calibration, allowing policy-makers to distinguish between health emergencies, threats, risks and concerns (2019, p. 1106). For our purposes, it can be assumed that Wenham's 'post-Copenhagen' response to the 'normalization of the exception' would require a fuller incorporation of metrics and indicators into decision-making on health security.

By way of a coda to this discussion, it is worth returning to the operative distinction in the present essay between Global North and South, and to question of whether COVID-19 has challenged this easy binary. Like other critical and analytical scholars to date, I have proceeded on the basis that global health governance is 'done' by the North to the South, locating this historically in the 'reconquest' of the Third World that attended on the decline of the New International Economic Order and the rise of structural adjustment in the 1980s. The impositions of the latter (e.g. privatisation of service provision, user fees, decay of sanitary infrastructure) had notoriously insalubrious consequences for public health. They were justified by their proponents in the development agencies and international financial institutions with reference to a pathological view of the Global South state as weak, corrupt, ineffective, riddled with factionalism and ethnic preference. A developmentally inflected contrast, underwritten by a mythic Weberian view of the state, positioned Europe and its settler colonial emanations as the norm from which African and other polities deviated, and which they must be induced or coerced into attaining. Political and legal development would underpin economic growth and official probity, and thus also the recovery of health and welfare provision. In all of this, the North was the blind spot from which dysfunctional, 'immature' states like Kenya were observed.

While its economic consequences have been harshest in the poorest regions of the world, the pandemic has also inverted the disciplinary gaze of global health governance, turning the observation back on the northern observer. This has been a consequence of disastrous epidemiologic and public health shortcomings in those states that had themselves led in conceptualising and implementing neoliberal development from the 1980s onwards. Most notably, the US, with 5 per cent of the world's population, had suffered 25 per cent of global deaths from COVID-19 by September 2020 (Nuzzo *et al.*, 2020). The UK was similarly overrepresented. Indeed, these outcomes contradicted the high rankings of both countries in the GHSI discussed above (Boyd *et al.*, 2020). As a result, the latter was criticised as an only partially effective guide to state preparedness and capacity (Abbey *et al.*, 2020). Ironically perhaps, Global South states who had benefitted from technical and financial support and constraint

[13]See Hirsch (2020).

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under US-funded global health initiatives often had more success in containing the virus and limiting deaths from it (Nuzzo *et al.*, 2020).

In truth, then, the pandemic has functioned as an *épreuve* in the Global North, too. As regards health diplomacy, many have remarked that it confirmed the rise of China as a global actor, pointing to a diminished role for Europe and the US, and correlatively increasing the leeway for African states looking to access medical equipment and vaccines free of intrusive governance conditions (Freymann and Stebbing, 2020). The test is also focused on (relative) state failure *within* the heartlands of global governance. In the case of the US, uneven access to health care, including testing, and a lack of public health co-ordination was a consequence of decades of neoliberalism 'at home' that aided the spread of the virus. An adequate political response was stalled by deadlocked factionalism within the US political system and the quasi-ethnic loyalties of American voters (Roberts, 2020). The latter only reinforced widespread popular distrust in government (Nuzzo *et al.*, 2020, p. 1391). For his part, former President Trump made a conspicuously vulgar performance out of repudiating the constraints of health governance, which the US itself had devised, funded and legislated for the rest of the world. Indeed, domestic incapacity in the face COVID-19 is seen as having further weakened the position of the US and the UK in global health (Gostin *et al.*, 2020; Wenham, 2020). It is important, of course, not to allow a sense of irony to obscure enduring differences of power and wealth. Nonetheless, we can observe here a politics of spectacle and distrust, of division and wilfulness, familiar from the work of African state theorists (Mbembe, 2000; Musila, 2015). The closing of that episode has been marked, according to some commentators, by the defeat of Trump and the return of the US from its chaotic, nationalistic *Sonderweg* to a position of renewed and enlightened global leadership.[14]

Conflicts of Interest. This paper forms part of the project COVID-19 in Kenya: Global Health, Human Rights and the State in a Time of Pandemic supported by an award of the Arts and Humanities Research Council (AH/V007963/1).

Acknowledgements. Thanks to Sharifah Sekalala for very helpful comments on an earlier draft, and to Edward Armston-Sheret and Sabrina Tucci for excellent research assistance. All responsibility for errors is mine alone.

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[14]See e.g. Noe (2020).

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Cite this article: Harrington J (2021). Indicators, security and sovereignty during COVID-19 in the Global South. *International Journal of Law in Context* **17**, 249–260. https://doi.org/10.1017/S1744552321000318

https://doi.org/10.1017/S1744552321000318 Published online by Cambridge University Press