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Coronavirus Disease (COVID-19) Pandemic

It's important for Africa to learn the disease trend and stringent measures by other countries then put the evidence-informed experience into context rather than just copying the majority.

Strengthening Institutional Capacity for Stronger Health Systems

The key to improve and transform health systems is deliberate, focused and intentional institutional capacity strengthening.

Strengthening Use of Health Evidence in Policies and Practice

Health researchers need to get political to maximise the impact of their research. Just as the link from policy to research needs to be strengthened, the link from research to policy also must be fortified.

Verifying the data and the facts

To address teen pregnancies decisively in Kenya, it is important that evidence plays a central role in determining interventions that can stump out the problem from its root cause.

EIPM: Understanding and tracking the outcomes we seek

To evaluate the impact of EIPM, there is need to develop measures that are flexible enough to accommodate different types of interventions, outcomes and changing contexts of the policymaking sphere.

Vector-borne diseases: Africa's Agenda 2063

Although vector control is an effective strategy for addressing vector-borne diseases, the evidence base for some key interventions is weak.

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AFIDEP News is the African Institute for Development Policy's newsletter. It is published twice a year to provide our stakeholders with updates of AFIDEP's programmes and highlight emerging policy issues in population dynamics and demographic dividend; health and wellbeing; transformative education and skills development; environment and climate change; and governance and accountability.

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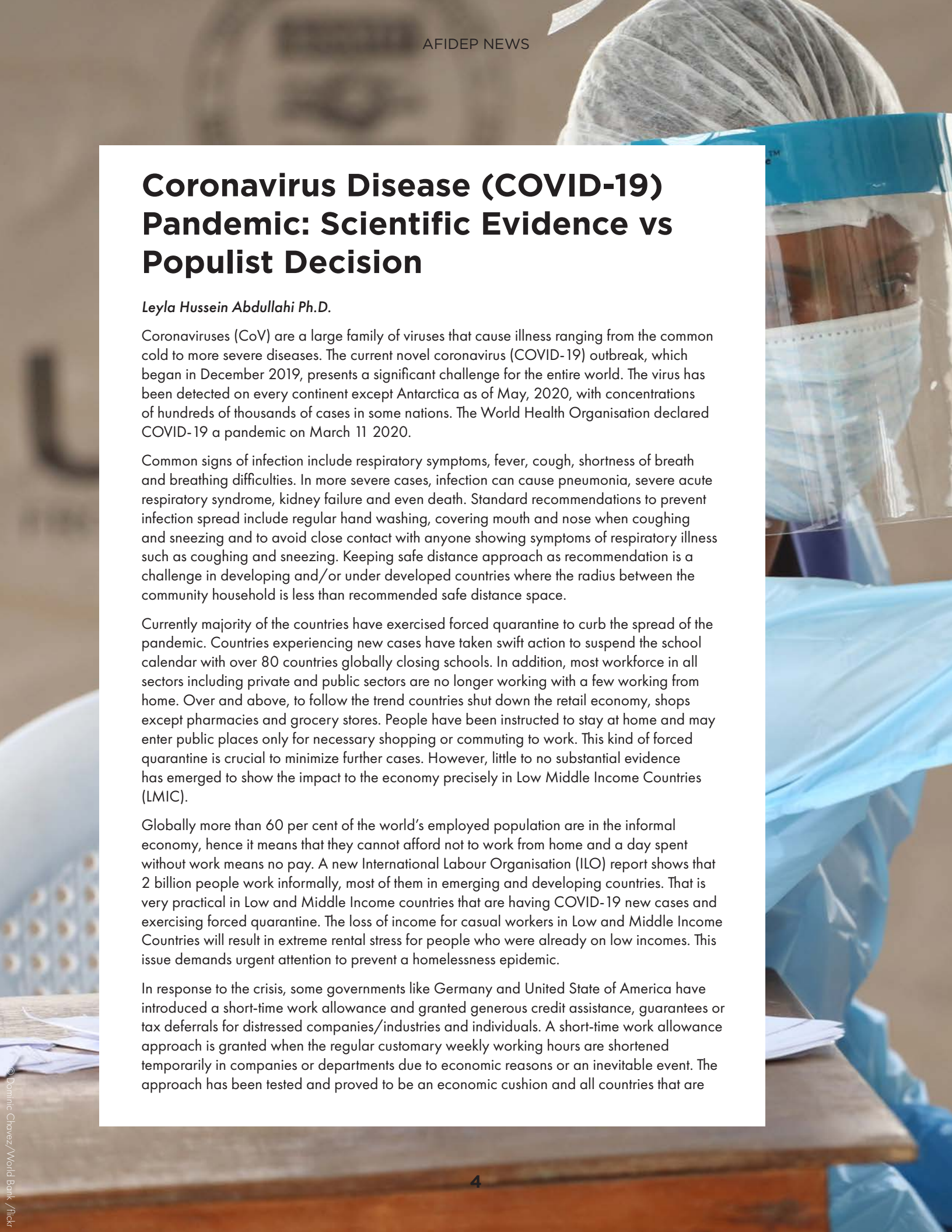

Coronavirus Disease (COVID-19) Pandemic: Scientific Evidence vs Populist Decision

Leyla Hussein Abdullahi Ph.D.

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases. The current novel coronavirus (COVID-19) outbreak, which began in December 2019, presents a significant challenge for the entire world. The virus has been detected on every continent except Antarctica as of May, 2020, with concentrations of hundreds of thousands of cases in some nations. The World Health Organisation declared COVID-19 a pandemic on March 11 2020.

Common signs of infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. In more severe cases, infection can cause pneumonia, severe acute respiratory syndrome, kidney failure and even death. Standard recommendations to prevent infection spread include regular hand washing, covering mouth and nose when coughing and sneezing and to avoid close contact with anyone showing symptoms of respiratory illness such as coughing and sneezing. Keeping safe distance approach as recommendation is a challenge in developing and/or under developed countries where the radius between the community household is less than recommended safe distance space.

Currently majority of the countries have exercised forced quarantine to curb the spread of the pandemic. Countries experiencing new cases have taken swift action to suspend the school calendar with over 80 countries globally closing schools. In addition, most workforce in all sectors including private and public sectors are no longer working with a few working from home. Over and above, to follow the trend countries shut down the retail economy, shops except pharmacies and grocery stores. People have been instructed to stay at home and may enter public places only for necessary shopping or commuting to work. This kind of forced quarantine is crucial to minimize further cases. However, little to no substantial evidence has emerged to show the impact to the economy precisely in Low Middle Income Countries (LMIC).

Globally more than 60 per cent of the world's employed population are in the informal economy, hence it means that they cannot afford not to work from home and a day spent without work means no pay. A new International Labour Organisation (ILO) report shows that 2 billion people work informally, most of them in emerging and developing countries. That is very practical in Low and Middle Income countries that are having COVID-19 new cases and exercising forced quarantine. The loss of income for casual workers in Low and Middle Income Countries will result in extreme rental stress for people who were already on low incomes. This issue demands urgent attention to prevent a homelessness epidemic.

In response to the crisis, some governments like Germany and United State of America have introduced a short-time work allowance and granted generous credit assistance, guarantees or tax deferrals for distressed companies/industries and individuals. A short-time work allowance approach is granted when the regular customary weekly working hours are shortened temporarily in companies or departments due to economic reasons or an inevitable event. The approach has been tested and proved to be an economic cushion and all countries that are

quick to make shutting down of activity nationwide should be replicating the approach which is a policy in developed countries to prevent job losses. However, for the African countries there are no economic boosters in place to cushion the citizens.

Coronaviruses are a large family of viruses that have been studied for decades, we presume that it's possible to look at the characteristics of similar viruses as a reasonable guide to this one. Nonetheless, the COVID-19 strain have met us by surprise, it is possible that an outbreak or pandemic of COVID-19 could occur in multiple waves or the virus might mutate to complex structure to present the disease with seasonal pattern in future.

It's important to learn the disease trend and stringent measures in place in other countries and put the evidence informed experience into context rather than following majority decision which are not evidence informed. For example, even though the forced quarantine might seem to work its evident the disease has a close to 14 days' asymptomatic window period, hence the new cases infected today will be evident in a fortnight. This is why countries who are surprisingly reporting the cases now might experience increased cases in the next coming weeks. On the other hand, those countries that were pioneers with this infection currently in recovery phase due to various measures put in place three weeks ago cannot guarantee recurrent state by similar disease once the quarantine is offset.

Majority of those countries that have big impact of coronavirus casualty or fatality are having aged population. Amid scarce evidence on the uncertainty swirling around the coronavirus pandemic, trends from other countries show the undeniable fact that the highest rate of fatalities is among older people, particularly those with underlying medical conditions. Depending upon what the emerging evidence starts to tell us on the impact of national age structures, it may be necessary to ensure readiness for a future wave of activity mostly in Africa where the majority are young population.

Currently the experimental trial and data are still to emerge for the testing of drugs and initial development of vaccines and/or improved therapies or tests to help reduce the impact of the disease. However, it's evident that the vaccination uptake among non-childhood phase is uncommon mostly among adulthood and/or elderly population. Therefore, with these novel vaccines in the pipeline studies focusing on improved understanding of adulthood/elderly vaccination are critical and will become increasingly relevant in the future.

Gathering evidence about effective interventions in order to inform decision-making going forward rather than following panic intervention that might not be one size fit all based on the context is crucial. On the economic perspective, a severe recession due to the disease can no longer be avoided, and some economists are already calling for governments to introduce measures to reinforce aggregate demand. But that recommendation is inadequate, given that the global economy is suffering from an extraordinary economic scenario. Researchers will need to keep emerging research under close review to curb the current evidence gap.

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HIGH-RES PROJECT: STRENGTHENING INSTITUTIONAL CAPACITY FOR STRONGER HEALTH SYSTEMS

Ann Waithaka, Leyla Hussein Abdullahi Ph.D., Hleziwe Hara and Ronald Manjomo

The quality, effectiveness, efficiency and performance of health systems is often hampered by weak and poor functioning institutional structures and processes. This is also coupled by barriers to evidence use in decision-making as well as weak capacity for research uptake. AFIDEP's experience and accumulated evidence in health care suggest that key to improve and transform health systems is deliberate, focused and intentional institutional capacity strengthening.

In advancing the need for priority focus on institutional capacity and evidence use in health decisions and policies, AFIDEP and partners are currently implementing a collaborative programme known as Heightening institutional capacity for government use of health research (HIGH-Res). The three-year project aims to strengthen institutional capacity for the use of health research in policy and programme decisions in Kenya, Malawi and Uganda. The project brings together various partners under the HIGH-Res East Africa Consortium with Ministry of Health (MoHs) of the three countries engaged actively as implementing partners.

Since its rollout in 2019, HIGH-Res country project teams have been undertaking the inception phase of the study which included conducting baseline studies in the three countries; Kenya, Malawi and Uganda individually. The studies were undertaken as part of impact evaluation to evaluate effectiveness and impact of interventions to generate evidence on what works in strengthening institutional capacity for research use in decision-making.

Having completed the baseline of the impact evaluations early this year, AFIDEP and partners officially launched and formalised the HIGH-Res project in the three countries. The launch of the project in Malawi and Kenya was marked by the dissemination of the findings of the baseline studies conducted between January and February 2020. Overall, findings from these studies confirmed the need for HIGH-Res interventions in the three countries and provided important information to inform the refinement of the HIGH-Res project interventions and activities.

HIGH-Res launch in Kenya

HIGH-Res was officially launched in Kenya on January 28, 2020. The launch event included a dissemination meeting to share findings of the baseline study conducted in Kenya and provided an opportunity for extensive consultations with top heads of MoH and various research institutes. The launch was attended by key health stakeholders who included Senior Advisor to the Principal Secretary for Health – Dr. David Soti; Director of the Research Directorate – Dr Charles Nzioka; Heads of MoH directorates, departments and divisions; heads of research institutes; and representatives of development agencies.

Dr Nzioka delivered the keynote speech on behalf of Health Permanent Secretary, Susan Mochache. While giving his remarks, he encouraged partners to focus on building capacity where it is weakest while working on institutionalising and ensuring sustainability where this is already doing well. He noted the need for a Ministry [MoH] that is performing well across all Divisions, Departments and Directorates.

According to the findings of the baseline study shared during the launch, results confirmed the need for the interventions proposed by the project. Overall, the results provided crucial lessons that would help project implementers to refine their interventions and approaches. In her presentation of the baseline findings, AFIDEP's Dr Rose Oronje appreciated that huge opportunities exist in Kenya that serve as entry points for HIGH-Res. Among them is supporting the realization of the government's Universal Health Coverage (UHC) which is Kenya's top priority. She noted that fast-tracking the realization of UHC has thrust research and evidence into the limelight. To this end, HIGH-Res would prioritize on supporting the strengthening of institutional capacities to regularly generate the evidence needed to drive the implementation of the UHC Agenda. This would also ensure the project remains relevant to the top leadership of MoH.

The dissemination of the baseline study results generated valuable discussions which recommended and/or committed to among others:

- MoH's Division of Research to lead the coordination with MoH Divisions on hosting regular dialogues where researchers are invited to present research on specific issues the Divisions are prioritising.
- Fast-track the efforts to build the capacity of TWGs in research use and conducting operational research so that their work is based on credible evidence.
- MoH's Research Division to regularly share priority research questions of the MoH and county governments with research institutes, either quarterly, bi-annually or annually; this will ensure the research they generate is responsive to needs of policymakers in the health sector.
- Need for regular forums between MoH leaders and leaders of research institutes in efforts to strengthen the role of research institutes in health sector decision-making.

Malawi Launch

In Malawi, the High-Res project was launched on February 21, 2020 and this also served as a dissemination meeting to

share key findings from the baseline study. The meeting was attended by MoH heads of Departments and Divisions, heads of research institutes, and representatives of development agencies. Specifically, these included the Chief of Health Services – Dr Charles Mwansambo and representatives from the Royal Norwegian Embassy, College of Medicine and the Department for International Development.

Dr Mwansambo delivered the keynote address and key in the speech was the government's commitment to supporting the HIGH-Res project. The support would enable the project to strengthen existing institutional systems and structures to enable a culture of evidence-informed decision-making (EIDM). In his speech Dr Mwansambo expressed hope, noting that, "this project will be beneficial to all health research stakeholders and that it will positively change the nation's research culture and maximize the utilization of research findings in policy development".

Dr Oronje's presentation on the baseline study results highlighted how the findings would inform the planning of the project as well as allow feedback and consultations with the stakeholders - most of whom were interviewed during the study. Discussions during the dissemination with top heads from MoH as well as research institutes generated crucial recommendations and commitments. Leaders noted and committed to not only support but be actively involved in the project's interventions including: the development of an evidence checklist to require and enable increased use of evidence in decision-making; and the review and revision of terms of reference for Technical Working Groups (TWGs); as well as improving the general coordination of TWGs.

Following the launch of the project in the country, the HIGH-Res project team has engaged Malawi MoH to strengthen its institutional capacity to use evidence in decision-making. Currently, the project together with the MoH is developing Terms of References (TORs) for research focal persons, development of evidence checklist, reviewing of TORs for technical working groups, mapping of research and training institutions, identification of research focal persons and support in the development of a strategic plan for the implementation of the Ministry's Health Research Policy.

HIGH-Res in Uganda

High-Res implementation in Uganda was formalised with the signing of a memorandum of understanding (MoU) with the Uganda MoH. The MOU signing came as a result of one-on-one consultations with MoH top leaders early in the year. Results of the baseline study were also presented to the MoH's performance review meetings. The baseline study revealed among others the lacking linkages and platforms for the MoH to interact and exchange information with researchers. This points to the need for the MoH to introduce platforms through which researchers can regularly present their research to relevant policymakers and staff to inform MoH's decision-making.

AFIDEP had planned to disseminate the baseline study findings with Uganda's MoH senior management and leaders of research institutes but this has been delayed due to the on-going COVID-19 pandemic. However, consultations with these heads will be prioritized once the COVID-19 situation improves.

HIGH-Res' COVID-19 evidence response

COVID-19, which was declared a pandemic on March 11, 2020, by the World Health Organization has caused disruption across every sphere; from health, economy, social life to restrictions on movements and gatherings among others. For HIGH-Res, the pandemic has caused the delay of planned project activities. It has also hindered effective engagement with partners particularly MoHs of Kenya, Uganda and Malawi who have shifted all their focus to COVID-19 response.

In light of the COVID-19 disruption, HIGH-Res project teams have had to rethink approaches to planned activities and adapt to focusing on project activities that can be conducted remotely. On the other hand, project teams have identified an opportunity for the project to provide evidence for partner MoH's that will inform country responses.

In Uganda, HIGH-Res has provided three rapid evidence reviews upon requests from the Uganda MoH. In Kenya, HIGH-Res project team is currently (between April 20 – May 31, 2020) conducting one rapid review, and a knowledge, attitudes, perceptions, and practice (KAPP) survey to improve the Kenya MoH's COVID-19 responses. In Malawi, HIGH-Res project team are in discussions with the MOH to identify priority policy gaps to inform evidence synthesis that is responsive to the country's needs and context. HIGH-Res project teams will continue to monitor the COVID-19 situation and offer the necessary support to the project's partner MoH's to generate evidence that can improve responses and possible solutions to beat COVID-19.

ADVANCING EVIDENCE USE IN HEALTH: LAUNCH OF THE KENYA HEALTH AND RESEARCH OBSERVATORY (KHRO)

Rose Oronje Ph.D. and Ann Waithaka

Accessing evidence remains one of the major barriers mentioned by policy-makers as hindering their use of evidence in decision-making. To address this barrier, the Kenya Ministry of Health (MoH) in 2014 initiated efforts to establish a knowledge translation platform (KTP) that would comprise, among others, a repository of all health research conducted in Kenya. At the time, AFIDEP supported the MoH to conceptualise and define a KTP, drawing on lessons of existing KTPs around Africa.

Around the same time, the World Health Organisation (WHO) Kenya office approached the MoH to support the establishment of a Health Observatory. This provided opportunity to combine the KTP and the Observatory into one platform since both were focused on availing information on the health sector in Kenya at the touch of a button to inform decision-making. The MoH has worked on the development of this platform over the years with support from the WHO, AFIDEP, World Bank and other partners. These efforts culminated in the launch of the Kenya Health and Research Observatory (KHRO) on January 22, 2020 in Nairobi, Kenya.

Present to mark this milestone included, County Executive Members of Health, County Directors, County Representatives, Kenya Health Federation, representatives of partner agencies (World Health Organization (WHO), Japan International Cooperation Agency (JICA); Development Partners in Health (DPHK, UNICEF, UNFPA, USAID and World Bank).

About the Kenya Health and Research Observatory

KHRO is a web-based portal developed to provide a one-stop-shop for health data and research. It is therefore a repository for all health research conducted in Kenya, as well as a tool for accessing, querying and running basic reports on health indicators in the country. The platform also provides tools to strengthen monitoring of the health sector performance. It, therefore, offers a rich platform for translating data and research evidence for informing policy, programme and practice decisions.

The platform is designed to facilitate multi-stakeholder collaboration and partnership in accessing and using information to strengthen national health information systems. The ultimate goal of this platform is to empower and advance the Evidence-Informed Decision-Making agenda in the health sector. Additionally, KHRO will facilitate monitoring of health indicators at the county and national level in tracking efforts towards the attainment of Universal Health Coverage (UHC).

Development of KHRO

The concept of KTPs was initiated by the WHO beginning 2005 and through WHO's support, numerous national and regional KTPs have been established across the globe. KTPs have been found to improve the technical capacity to promote EIDM, the interaction between researchers, and policy audiences and production of relevant evidence.

It was during the 62nd Session of the WHO Regional Committee for Africa in 2012 that Ministers of Health of the 46 member states including Kenya called on WHO to support them to establish National Health Observatories. Consequently, in 2017, WHO came on board to work with MoH-Kenya and with support from the World Bank begun developing the KHRO platform.

The future of the KHRO platform

The KHRO platform is expected to foster collaborations and engagements among policy-makers, researchers, practitioners and other stakeholders in the health sector. Additionally, it will maximize use of health data and evidence in decision-making processes. AFIDEP is keen to continue supporting the growth, refinement, and enrichment of the KHRO platform by providing technical assistance when called upon and being a source of quality and reliable health data and research.

STRENGTHENING USE OF HEALTH EVIDENCE IN POLICIES AND PRACTICE

Emma Heneine and Claire Jensen

The whole world is now witnessing the profound influence of health on all aspects of life. In these times of COVID-19, it is not just public health that is being affected, but also businesses, travel, schooling, job security, and social networks, just to name a few. Gone are the days when health was only a consideration in clinics and hospitals. Now we see very clearly that health is omnipresent—it transcends individuals, health facilities, sectors, and countries. Despite this reality, our policies and systems are ill-equipped to prepare for and respond to health challenges in our globalised and interconnected world. Why do these gaps exist, and what can be done about it?

At AFIDEP, our mission is to bridge the work of researchers, policymakers, and practitioners. In health, such work is especially relevant. Researchers and academics can do a lot in generating information, but too little of it is reflected in policy, especially in policies which are not directly health-related. Decisions are made at country level on measures to control infectious diseases, for example, without aligning the policies to other health issues, or neighbouring countries' policies or even to non-health specific policies in areas like immigration and national security. The global community is now learning (the hard way) that we are, in fact, an incredibly and increasingly interconnected global community that needs integrated, cross-sectoral systems that take into account the most credible and comprehensive evidence available.

The impact of integrated systems which are informed by evidence versus those which are fragmented and based in mere opinion is perfectly exemplified by differing COVID-19 policy responses and the resulting levels of infections and deaths. Countries like China, for example, have made an incredible comeback by instituting strict quarantining measures. On the other hand, we are witnessing how countries like the United States, Italy and Spain are now

struggling to keep up with all the COVID-19 cases due, in large part, to their slow acknowledgement of emerging research and evidence on the severity of COVID-19. However, an evidence-informed policy response, albeit late, can still save lives – parts of the United States are saw a slowing of transmission as a result of stay-at-home and social-distancing policies.

The disconnect between health researchers, policymakers and practitioners exists for several reasons. First, people often assume that working within the health sector means being either a doctor or a researcher. While both professions are, undoubtedly, integral to successful health sectors, they are only small pieces of the puzzle. In reality, substantial efforts are needed to bridge the work of researchers and health workers together—to ensure researchers' evidence is applied by practitioners in the health system and to ensure that all other systems are enabling factors for the health sector to do its job well. Unfortunately, many health sectors have and are developing under this assumption that health systems are simply a product of strong research and health care providers. However, that mentality fails to acknowledge the critical role of policymakers and the major influence of other industries and sectors on health.

The gap between research and practice is worsened by the fact that policymakers, themselves, don't always recognise their responsibility to enact policies that are grounded in comprehensive evidence and research. To address this, AFIDEP has developed a training for policymakers in evidence-informed policy-making (EIPM). The training has been delivered to nearly 80 Ministry of Health and Parliament staff from Kenya and Malawi, with participants trained in defining a policy question, and accessing, assessing, synthesizing, and applying evidence. Feedback has highly been positive, and resulted in participants championing EIPM; in 2019, Ms. Velia Manyonga, Head of the Research Division at the Parliament of Malawi and a beneficiary of the training programme, was the first recipient of the African Evidence Network (AEN)'s Africa Evidence Leadership Award (AELA).

Lastly, health researchers too often deem their job done once their findings are published in peer-reviewed journals and presented at conferences. However, if the knowledge generated is to have an impact, the work is far from over. Ultimately, the surest way to ensure that society benefits from research evidence is by enacting policies that can have widespread influence if they are well implemented and integrated. Because many health researchers don't consider their jobs political in nature, they tend to shy away from engaging in politics and policy. AFIDEP has realised, however, that health researchers need to get political to maximise the impact of their research. Just as the link from policy to research needs to be strengthened, the link from research to policy also must be fortified.

To this end, AFIDEP developed a five-day Policy Engagement and Evidence Uptake Training for early-career African researchers to equip them with the tools needed to develop and implement policy engagement strategies. The training re-orients policy- and influential decision-makers as priority audiences and end-users of researchers' work. Over the last five years, the training has been adapted for several audiences including African lung health PhD and post-doctoral students, African vector control researchers, and a range of scholars from the African Academy of Sciences. Each training has seen some initial push-back from participants, as adding hefty policy responsibilities for already complex and time-constrained research can be a hard sell. However, by the end of each training, participants have completely bought-in to the need for researchers to engage with policy-making processes and have expressed excitement about taking forward their policy engagement plans.

The demonstrated and potential impact of the training is remarkable. For example, many of the participants have gone on to conduct policy analyses as part of their research studies, with others developing policy briefs about their research areas. Trainees are equipped with the critical skills and knowledge needed for policy engagement: they can integrate policy analysis in their research, map key stakeholders, critique and outline policy briefs, develop tailored lay summaries of their research, and communicate their research topics in terms of policymakers' interests. Overall training evaluations show a double-digit increase in average scores between pre and post-test. Ultimately, participants' biggest piece of feedback is the need for more time for each module and activity...basically, one week is not enough! For entomologist Elizabeth Bandason, the training had a profound impact. She notes, "being a scientist who has spent so much time glued to a laboratory bench finding answers on why insects behave the way they do, my focus was on getting results, I did not care so much about the so what? Participating in the AFIDEP training, changed my whole perspective on my research. I learned to communicate my research in the simplest way and I was able to answer the so what?"

There remains much work to address the disconnect between health research, policy, systems, and delivery as evidenced by the novel COVID-19 pandemic. AFIDEP's capacity strengthening for researchers and policymakers is an important step in bridging the gap between research and policy. Researchers, like Ms Bandason, and policymakers, like Ms Manyonga, demonstrate that there is a demand for and value in synchronising research, policy and practice. Such work is a promising step towards a future where health evidence is mainstreamed into our governing policies and systems for improved health outcomes in Malawi, Kenya, across the continent, and beyond.

LOCAL EVIDENCE URGENTLY NEEDED IN AFRICA'S COVID-19 RESPONSES

Leyla Hussein Abdullahi Ph.D.

The World Health Organization (WHO) declared COVID-19 a pandemic on March 11, 2020. All the continents except Antarctica have so far reported thousands of coronavirus cases and/or deaths. Globally, more than a million cases have been reported with 24% of deaths affecting a broad range of ages. Africa has been lucky to have a delayed onset of the spread of COVID-19. The continent has had the benefit of time to learn from measures and contingencies that are working in other countries. However, there is need to take caution not to generalize and mirror policies being implemented in other places without consideration of Africa's unique context i.e. demographic structure, population, disease burden health care systems, and living conditions.

Globally, coronavirus has spread rapidly and countries are using various measures to curb the pandemic disease. These measures include complete and/or partial lockdowns, shifting to remote working, online schooling, promoting hand-washing, and social distancing. Seemingly, many countries have adopted lockdown policies where majority of citizens are advised to stay home and prepare for what could be months of isolation and social distancing. However, some of the recommended measures are not practical in the African setting because of various reasons. For instance, a significant populace lives from hand-to-mouth relying on daily wages, and total lockdown means no food. Also, Internet access is so limited that working remotely or online schooling is not possible for majority of the population.

COVID-19 could bring Africa's weak health systems to their knees

In ealry April, the Coronavirus had spread to just 39 African countries, reaching 8000 recorded cases and 334 deaths. As of May 13, every country in Africa had recorded a case, to date the continent has over 780,000 cases and over 16,000 deaths. There were concerns that the absence of cases was a result of lacking or weak testing capacity. WHO has been supporting African governments with early detection by providing COVID-19 testing kits, training health workers, and strengthening surveillance in communities. As of April, 47 out of 54 countries in the WHO African region could test for COVID-19, now all countries can conduct tests.

Early detection of cases is one of the measures of curbing the spread of coronavirus as it allows coronavirus-infected patients to be separated from non-infected people.

Experts are worried about COVID-19 rapidly spreading in Africa and numbers rising to those recorded in countries such as China and Italy previously and now the United States, Brazil and South Africa. A major concern is the fragile health systems in most African countries that often suffer from minimal or no medical supplies and equipment, inadequate funding, shortage of adequately trained healthcare personnel, and inefficient data transmission and use. These weak health care systems are currently overburdened by diseases such as malaria, HIV, tuberculosis, cholera, cancer, diabetes, and maternal and child health issues. Clearly, these systems currently have no capacity to deal with COVID-19. Experts therefore fear that the pandemic could be difficult to manage in Africa, and could cause huge numbers of deaths and grave economic problems if it spreads widely.

African countries must learn from own experiences of managing Ebola, polio and cholera

In the last three years, Africa has had significant experience having dealt with different epidemics like Ebola, polio and cholera. Hence, drawing lessons learnt on preparedness and response to previous epidemics is crucial in enabling African countries develop effective strategies to curb the spread of COVID-19. For example, there is undocumented evidence that Taiwan and Singapore took quick drastic measures to curb COVID-19 due to their experience with Severe Acute Respiratory Syndrome (SARS). Active surveillance network, among other, measures helped to control and prevent massive spread of the disease epidemics in their countries. Documenting evidence on the lessons from African countries that experienced and addressed Ebola could also be valuable in designing country responses to COVID-19.

A strategic approach is critical for African governments to combat this COVID-19 pandemic. For Africa considering her unique context, the strategy should focus on prevention and containment. Indeed, African governments can borrow valuable lessons from other countries who had earlier exposure with coronavirus such as Italy and China.

However, strategies and possible solutions of managing COVID-19 cannot just be generalized to African countries. This is because these strategies and solutions have been mostly implemented in high-income countries and may not necessarily work for Africa because of her unique contexts.

To begin with, the high levels of poverty in many African countries means that large proportions of African populations live on daily wages, which means complete lockdown directives pose serious challenges unless governments are ready and able to provide food provisions to the most vulnerable. Secondly, there is the issue of poor living conditions for large of proportions of populations in many African cities due to informal or slum settlements. Managing and preventing Coronavirus is likely to be particularly grave in urban informal settlements, which lack access to running water, people live in crowded housing structures and conditions, and poverty levels are rampant. These living conditions mean that the strategy of social distancing and self-quarantine may not be feasible. Similarly, many parts of rural Africa still do not have access to running water. For such communities, the intervention of constant hand-washing may not be feasible. Thirdly, there are also large displaced populations due to war and instability living in refugee camps in different parts of Africa. The conditions in these camps also mean that much of the strategies that have been applied in high income settings are unlikely to work in these settings. In most of these settings, interventions must go beyond sensitizing people to wash hands to offer practical assistance including setting up hand washing points and providing hygiene and sanitary facilities. You will not be surprised to find one toilet being shared among over 50 households in some informal settlements.

Evidence is key

Over and above, African countries need context-specific evidence to inform how they adapt global solutions being put forth to contain the spread of the virus, or to help them come up with their own unique solutions that can work within their contexts. Yet, unlike high income countries that have quickly dedicated resources to generating quick scientific evidence and solutions to COVID-19, African governments, amid limited resources, have not dedicated much resources to generate context-specific scientific evidence and solutions. Therefore, it is vital for the experts to provide lessons that African governments urgently need to inform the policy decisions they are making and implementing in response to COVID-19.

Certainly African leaders need evidence from African contexts and other similar contexts to provide practical policies and programmatic solutions to COVID-19. This context-sensitive evidence needs to inform the adaptation of global solutions to COVID-19 so that these are more responsive to Africa's unique context. In most African countries, however, the institutional systems and structures that can readily provide such locally relevant evidence are either weak or missing altogether. For instance, there are no existing evidence review and synthesis centres supporting policy decisions being made by ministries of health. At best, these ministries rely on university departments to provide the research needed, or have medical research institutes (such as the Kenya Medical Research Institute for Kenya) that are mandated to provide research needed for health sector decision-making. Even then, these university departments or medical research institutes receive very minimal funding from governments that in many cases they are unable to provide the research needed for health sector decision-making.

This is partly the reason why many African countries are simply replicating global solutions to COVID-19, with minimal adaptation of these because the local evidence needed to help adapt the global solutions is missing. In some cases, these governments are also not reaching out to local scholars and institutions to provide the evidence they need to adapt global solutions to Africa's contexts.

The African Institute for Development Policy (AFIDEP) is currently contributing to addressing the weak institutional capacities for readily access to evidence by ministries of health in Kenya and Malawi. This work, initiated in September 2019, hopes to support the two ministries to strengthen their existing structures for research and knowledge gathering, synthesis, and sharing in order to readily access and use evidence as and when needs arise.

This article has been published by both the Star Newspaper Kenya and Standard Newspaper Kenya.

TEEN PREGNANCY IN KENYA: VERIFYING THE DATA AND THE FACTS

Elizabeth Kahurani

Reports of a spike in teenage pregnancies across Kenya during the COVID-19 pandemic lockdown were met with shock, angst, and disbelief. Additionally, the data on prevalence circulating on various platforms was contested and cited as being exaggerated with ulterior motives.

Given the seriousness of this matter, the African Institute for Development Policy (AFIDEP) sought to validate and compare the number of teenagers presenting with pregnancy from the Kenya Health Information Management System (KHIS) in 2020 to 2019. The data shows that the number of girls, aged 10-19 years, presenting with pregnancy in January-May in 2019 and 2020 are not that different, and leaning more towards a decline in 2020. Decline in use of health facilities during the COVID 19 period and delay in validation of the latest figures in 2020 may account for lower numbers in 2020.

A quick trend analysis shows that Nairobi county is leading with 11,795 teenage pregnancies in the period Jan-May 2020. This is slightly higher than last year's figures in the same period where there were 11,410 cases reported. Kakamega county is a close second with 6,686 cases compared to 8,109 cases last year. Machakos county, that has been the focus of the latest public outcry on teen pregnancy ranks number 14 with 3,966 cases registered this year compared to 4,710 cases last year. From all the counties, the total numbers reported for the period January-May 2020 are 151,433 compared to 175,488 for the same period in 2019. See a table summarizing the numbers for each county here.

It is important to note that the KHIS data only captures cases reported in the health sector and so it is possible that there are many other pregnant girls who are not counted because they have not been to the health centres. On the other hand, briefings from the Ministry of Health in the past week indicate that these numbers also capture multiple visits and hence are not reflective of the exact number of pregnancies. One thing we can safely conclude from the data available is that the evidence presented does not support an upsurge in teenage pregnancy because of COVID-19 school shutdown and movement restrictions.

The reality is that teenage pregnancy is high in counties across the country, and has remained so for some time now despite the periodic outcry when numbers on teenage pregnancy are released. This therefore calls for a redoubling of efforts and change intact on how to address this menace that is holding back our girls from maximizing their full potential.

The gravity of high teenage pregnancy is not new in Kenya. Data from the Demographic and Health Surveys show that almost 2 out of 10 girls between the ages of 15 and 19 are reported to be pregnant or have had a child already. This trend has been fairly consistent for more than two decades with little change in prevalence between 1993 and 2014.

Teen pregnancies are a major challenge for socioeconomic development because they deprive our young girls the opportunity to further their education and attain their career goals. It also exposes them and their children to major health risks. According to World Health Organisation, "pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally."

While teenage pregnancy in Kenya is high and needs to remain at the top of the government's political agenda, it sporadically gets into public discourse triggered by certain events, after which it gets buried and we continue with business as usual. The last time this issue headlined and drew as much public uproar was during the national examination period in 2018 with reports of several young girls pregnant or giving birth while sitting for either their Kenya Certificate of Secondary Education and Kenya Certificate of Primary Education examinations.

To turn the tide and protect our young girls from teen pregnancies, there is urgent need to address systemic drivers of teen pregnancies by fully funding and consistently implementing cost-effective programs. Cultural, religious, and socio-economic factors that contribute to this problem are multiple and layered and interventions for addressing these are well known. We need to confront hard truths and realities of the issue with honesty and openness.

Efforts to address teenage pregnancies and other sexual and reproductive health matters are resisted by parents, religious leaders, political leaders and other stakeholders despite the mounting evidence that young people are initiating sex earlier than in the past. Proven interventions like appropriate sexuality education are also often dismissed with the view that they would encourage young people to indulge in sex. In order to address this challenge decisively, it is important that evidence plays a central role in determining interventions that can stump out the problem from its root cause.

EVIDENCE-INFORMED POLICYMAKING: UNDERSTANDING AND TRACKING THE OUTCOMES WE SEEK

Jessie Mphande

Evidence-informed policymaking (EIPM) entails policymakers using the best available evidence in making policy decisions. Many stakeholders have in recent years invested in interventions that enhance EIPM, particularly in low and middle-income countries (LMICs). Policymaking in the public sector requires diverse actors such as policymakers, practitioners, knowledge intermediaries, researchers, civil society organizations and funders. These actors weigh different types of evidence in ever-changing contexts of political priorities, competing interests, cultural values and limited resources. You may be wondering, what is this evidence and what constitutes evidence? Most EIPM experts have leant towards a broad definition of what evidence is: "the available body of facts or information indicating whether a belief or proposition is true or valid."*

How do we measure the success of EIPM?

Literature has not provided enough information on how the impact of EIPM can be measured. EIPM strategies have focused on capacity building, relationship building, co-production of knowledge, technical assistance and synthesis of research evidence. These strategies have either been implemented as stand-alone strategies or together with others. Measuring the impact of these EIPM strategies becomes difficult as policymaking is a complex process.

Two schools of thought on policymaking have been widely debated in literature. The first views policymaking as an

orderly cycle with independent neutral inputs at each stage which progressively improves the policy and its implementation. However, this is likely to be more applicable in situations involving randomised experiments where results demonstrate what works.

This begs the question: What works then where politics plays a central role in determining what policies are adopted? This leads us to the second school of thought which recognizes that policymaking can be disorderly, complex and political where evidence is one factor weighed alongside political priorities. Interventions developed from the second school focus on changing norms, political incentives and governance which present a challenge in measuring the impact that they have.

What have we learnt?

1. Norms and procedures in government are constantly shifting and very little is institutionalised.
2. Due to the bureaucratic process of policy development, policy adoption is delayed and evidence loses its currency.
3. Governments possess weak accountability systems and therefore data quality is not reviewed prior to decision making.
4. Many African governments would rather use consultants many of whom possess a limited understanding of the local political economy or EIPM principles.
5. African governments are dependent on external funding for conducting policy processes.

What has AFIDEP done to build a culture of evidence use? What needs to be done?

At AFIDEP, we seek to change the belief system and values of policymakers to a culture where evidence is always considered when making decisions. We recognise that EIPM is not an endpoint but a dynamic and evolving process. In 2018, we undertook a study which involved a review of literature, drawing from our experiences and key informant interviews with 24 experts involved in the policymaking process. We identified many barriers in evidence use some of which are; individual skills and behaviours, organisational skills and structures, networks and structured interactions between policy and evidence actors and institutional level barriers.

Drawing from AFIDEPs experience and insight from respondents as well as literature, the following outcomes have been identified;

Through the Malawi Parliamentary Support Initiative (MPSI), AFIDEP strengthened the technical knowledge and skills of Parliament Secretariat in budget analysis, financial scrutiny and evidence-informed decision-making.

AFIDEP joined African policy-makers at regional forums, including at the Network of African Parliamentary Committees of Health (NEAPACOH) meeting and a National Symposium on Population and Development by the Ministry of Health in Malawi, to inform national actions and commitments ahead of the Nairobi Summit - International Conference on Population and Development (ICPD 25).

1. Government officials expect to review a range of evidence and the quality of evidence when developing policy products, and senior leaders require evidence to be referred to in policy submissions (behaviours). In order to instill this culture, AFIDEP engaged the Malawi Parliament through the Malawi Parliamentary Support Initiative (MPSI) project to enhance the capacity of Parliamentary committees to request for and use evidence. Committees gather evidence from various stakeholders and then draw up recommendations that are presented to the House to be debated before a policy is adopted.

2. Policy development processes engage with evidence from diverse stakeholders and multiple perspectives from civil society, communities, research and businesses, strengthened by functional accountability mechanisms and networks (process).

3. Routine evidence use is facilitated by evidence sharing platforms, key staff and units with an evidence role providing research reviews, and functioning statistical data and M&E systems (structural). As part of our work, we have equipped units within the Malawi Parliament with the necessary skills to effectively contribute to the use of evidence in Parliament through the MPSI project and by inspiring political behaviour and reforms to improve performance of Parliament through the Malawi Parliament Enhancement Project (MPEP).

4. Routine evidence use is institutionalised, reinforced, incentivised and monitored through processes and standards, supported by senior managers, and reinforced by political commitment from the top levels of government (structural/process). For instance, under the MPSI project, the Malawi Parliament adopted guidelines for calling for and using research evidence which will contribute to policymakers generating relevant evidence needed to inform policy.

5. Senior government leaders invest in and provide funding for research, knowledge translation and R&D for industry.

To evaluate the impact of EIPM, there is need to develop measures that are flexible enough to accommodate different types of interventions, outcomes and changing contexts of the policymaking sphere. Drawing from the examples of the MPSI project above, the goal was to ensure that decision-makers capacity is built to enable them to request for the relevant evidence on various policy positions even in the absence of EIPM experts.

Nyovani Madise (extreme left), AFIDEP's Director of Development Policy and Head of Malawi office is the new Vice President of the Union for African Population Studies (UAPS), a regional scientific body that generates evidence on population and its application for development planning in Africa.

Through the Malawi Parliament Enhancement Project (MPEP), AFIDEP is addressing both the political and technical bottlenecks that limit the capacity of parliament to effectively fulfil its mandate by engaging the leadership of political parties, supporting the Legal Affairs Committee and the Parliamentary Service Committee, supporting media discussions on parliament and its role and facilitating conversations between parliament's leadership and the Executive, in championing evidence-informed decision-making.

* https://en.oxforddictionaries.com/definition/evidence

IF WE DON'T ACT NOW, VECTOR-BORNE DISEASES WILL GET IN THE WAY OF AFRICA'S AGENDA 2063 AND SDGS 2030

Rose Oronje PhD., and Nurudeen Alhassan PhD.

Vector-borne diseases (VBDs) such as malaria, dengue and yellow fever, cause many illnesses and deaths in Africa. Malaria alone kills over 400,000 people every year, mostly in sub-Saharan Africa. This undermines socio-economic development in the sub-region.

Despite malaria being the most prioritised diseases in the region, progress is stalling. This is largely because the current tools for preventing these diseases are either inadequate, outdated or failing due to insecticide resistance.

Although vector control is an effective strategy for addressing VBDs, the evidence base for some key interventions is weak. The few large-scale vector control programmes are focused on malaria and their impact on other mosquito-transmitted diseases is rarely assessed.

The partnership is generating new research and tools for integrated vector control

In 2017, a research Partnership was launched to reduce the VBDs through effective, locally appropriate, sustainable vector control. The Partnership for Increasing the Impact of Vector Control (PIIVeC) brings together leading research institutes and national disease control programmes in Burkina Faso, Cameroon and Malawi to develop evidence-based solutions for integrated vector control.

PIIVeC is generating new knowledge and tools, building local research capacity in vector control, and reinforcing links between researchers and policymakers. These efforts by PIIVeC are timely because apart from malaria, outbreaks of other VBDs such as sleeping sickness and dengue are increasing and spreading in regions where they have never been a threat. This means that African countries and their development partners must urgently focus their limited resources on the most effective and integrated vector control efforts if they are to make progress.

African Union's Agenda 2063 will not be achieved if vector-borne diseases are not contained. Indeed, one component of these aspirations is to make "African people have a high standard of living, and quality of life, sound health and well-being". The SDGs will also not be realised if we don't focus efforts on preventing vector-borne diseases.

PIIVeC is generating much-needed knowledge and tools to effectively tackle VBDs. According to the Lead Researcher in Burkina Faso, Dr Roch Dabire, "PIIVeC is a scientific pathway to evaluate and propose effective tools for vector control. It is also a technical platform to share and discuss vector control issues with civil society and policymakers".

This research is being conducted by teams comprising world-leading and aspiring researchers as part of building local capacity for vector control research in African countries. Indeed, ten aspiring researchers who have recently completed their PhDs are involved in this research in the three countries.

Prof. Hilary Ranson, the Partnership's Lead Investigator, says "one of the exciting aspects about PIIVeC is how it is bringing together individuals, institutes and sectors to work across multiple diseases; traditionally each vector-borne disease was tackled separately with little communication between programmes but there is so much we can learn, and efficiencies to be gained, by looking at the burden of vector-borne disease as a whole'.

The Partnership is also responding to the priority needs of governments

PIIVEC is also working with Ministries of Health (MoHs) to identify their evidence needs and support operational research to meet those needs. PIIVEC and the MoHs have already identified priority operational research areas.

Some ongoing PIIVEC research

1. Characterising vector behaviours and the risk of malaria infections in communities in southern Malawi (read more here: https://www.piivec.org/characterising-vector-behaviours-and-the-risk-of-malaria-infections-in-communities-in-southern)
2. Molecular markers of metabolic resistance to pyrethroids in Anopheles coluzzi, major malaria vector (read more here: https://www.piivec.org/molecular-markers-of-metabolic-resistance-to-pyrethroids-in-anopheles-coluzzii-major-malaria-vector)
3. Assessment of the epidemiological risk of Chikungunya, Dengue and Zika viruses outbreaks in Cameroon (read more here: https://www.piivec.org/assessment-of-the-epidemiological-risk-of-chikungunya-dengue-and-zika-viruses-outbreaks-in-cameroon)
4. The effect of disengagement on efficacy of vector control interventions (read more here: https://www.

piivec.org/the-effect-of-disengagement-on-efficacy-of-vector-control-interventions)

5. Impact of native Wolbachia symbionts in host mosquito Anopheles gambiae (read more here: https://www.piivec.org/impact-of-native-wolbachia-symbionts-in-host-mosquito-anopheles-gambiae)

6. Analysis of financing mechanisms for vector-borne disease control in Burkina Faso (read more here: https://www.piivec.org/analysis-of-financing-mechanisms-for-vector-borne-disease-control-in-burkina-faso)

7. Peri-domestic ecology and behavior of Aedes sp. Mosquitoes: West African evidence base for effective control of urban arboviruses (read more here: https://www.piivec.org/peri-domestic-ecology-and-behaviour-of-aedes-sp-mosquitoes-a-west-african-evidence-base-for)

8. Microgeographic structure, vector control and population dynamics of Glossina palpalis: Impact on human and animal trypanosomiases in the Campo focus, southern Cameroon (read more here: https://www.piivec.org/microgeographic-structure-vector-control-and-population-dynamics-of-glossina-palpalis-palpalis)

9. Impact of vector symbionts on malaria transmission and control in Cameroon (read more here: https://www.piivec.org/impact-of-vector-symbionts-on-malaria-transmission-and-control-in-cameroon)

The potential impact of vector control in Malawi

The blue and black fabric is visually attractive, and a plastic bottle attached to the target emanates olfactory attractants (a blend of acetone, octenol, and phenols). The entire target is impregnated with insecticide.

Dr. Elizabeth Bandason, a PIIVeC research fellow based at the Malaria Alert Centre, College of Medicine, is about to conduct an experimental Home-Usage Test (HUT) study in Chikwawa district, Malawi.

Vector-borne diseases (VBDs) such as malaria, dengue and yellow fever, cause many illnesses and deaths in Africa. African countries and their development partners must urgently focus their limited resources on the most effective and integrated vector control efforts if they are to make progress.

The PIIVeC partnership is funded by the UK Research and Innovation Global Challenges Research Fund (GCRF).

PUBLICATIONS

1. ***Journal:*** Review of published evidence on knowledge translation capacity, practice and support among researchers and research institutions in low- and middle-income countries.
https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-019-0524-0

2. ***Policy brief:*** Evidence to Inform How New Bed Nets Can Be Used to Prevent Malaria in Malawi.
https://www.afidep.org/publication/13375/

3. ***Journal:*** Digital health and financial good-governance: a mixed-methods study of patient revenue capture in Malawi.
https://www.joghr.org/article/12258

4. ***AFIDEP Newsletter:*** July – December 2019 Newsletter
https://www.afidep.org/publication/july-december-2019-newsletter/

5. ***Policy paper:*** Jobs and Migration: An African Perspective.
https://www.afidep.org/publication/jobs-and-migration-an-african-perspective/

6. ***Policy paper:*** Adolescents (age 10 – 19) Presenting with Pregnancy at Health Facilities.
https://www.afidep.org/publication/adolescents-age-10-19-presenting-with-pregnancy-at-health-facilities/

7. ***Policy paper:*** Medium and long-term impacts of a moderate lockdown (social restrictions) in response to the COVID-19 pandemic in Malawi: A rapid cost-benefit analysis.
https://www.afidep.org/publication/medium-and-long-term-impacts-of-a-moderate-lockdown-social-restrictions-in-response-to-the-covid-19-pandemic-in-malawi-a-rapid-cost-benefit-analysis/

8. ***Policy brief:*** The Role of Vector Control in Preventing and Responding to Rhodesian Human African Trypanosomiasis (rHAT) in Malawi.
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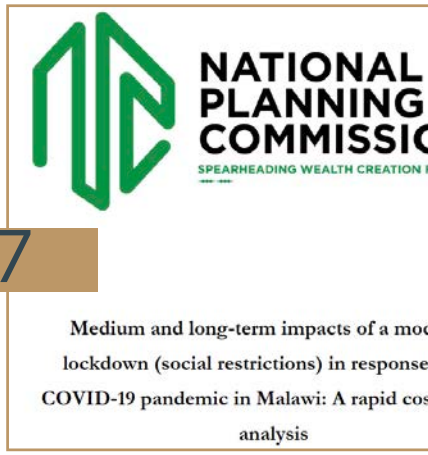

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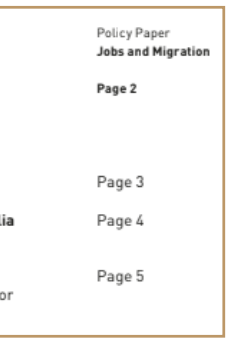

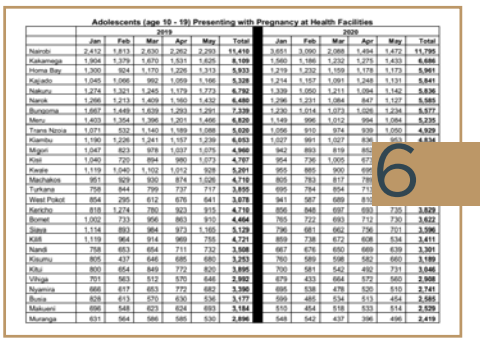

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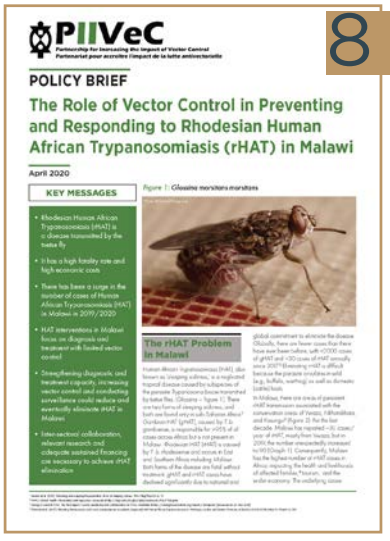

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New staff

Hellen Kamau

Hellen serves as the human resource officer. Her role involves recruitment, supporting staff through developing policies and managing procedures.

Jesse Mphande

Jesse provides support in policy analysis, knowledge synthesis and translation and research in governance and population programmes.

Leyla Hussein Abdullahi, Ph.D.

Leyla provides support to programmes in the health and wellbeing focus area. This includes technical support in the monitoring of programmes, impact evaluation research and evidence research synthesis.

Masida Nyoni

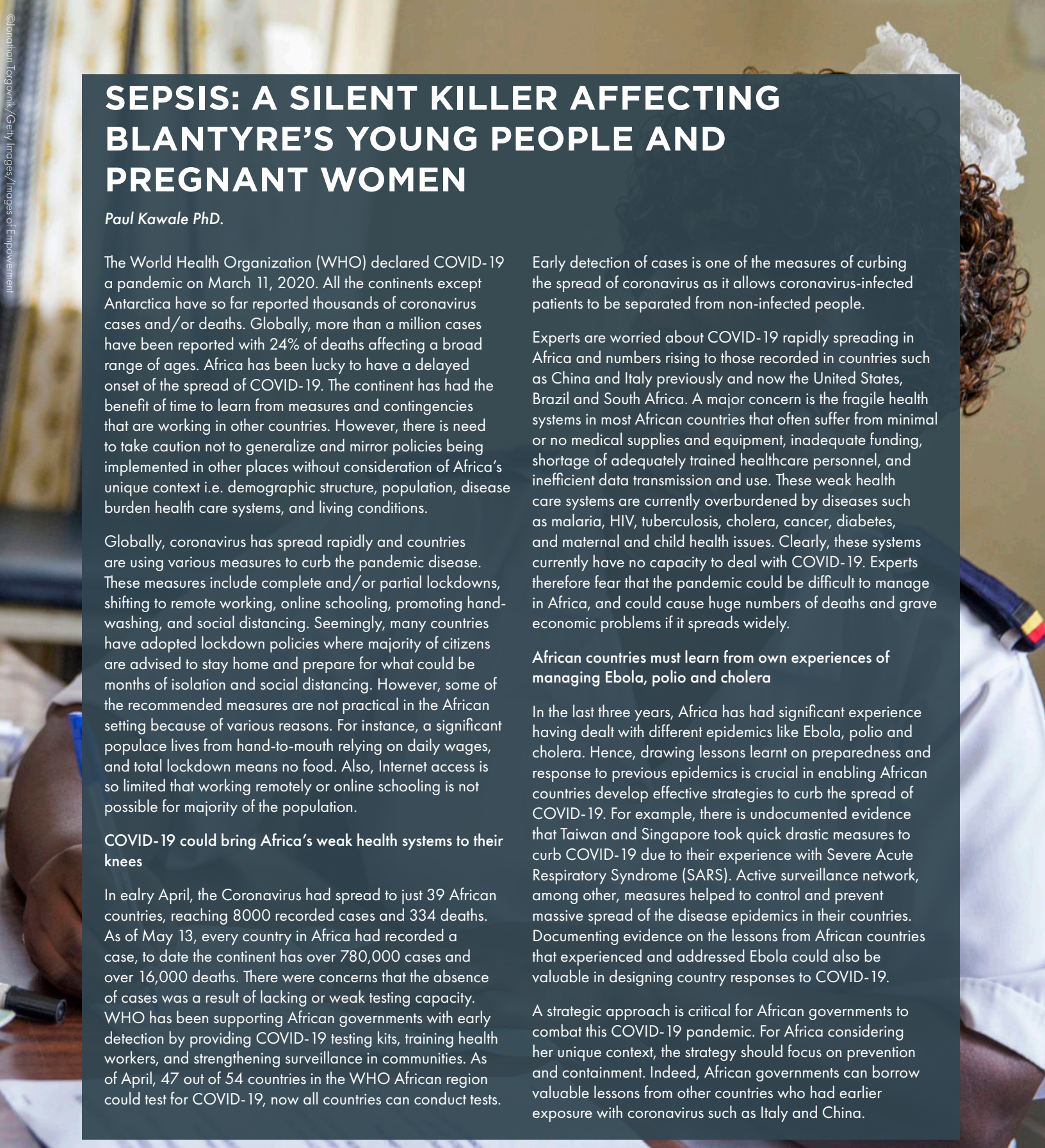
Masida provides technical support and advice to project Managers in managing project finances, treasury management and coordinating internal and external audits.

Medika Medi

Medika provides support in multimedia content generation and support in strategic communications.

Tumaini Malenga

Tumaini supports programmes in the health and wellbeing focus area, specifically relating to public health and health policy and in partnership with the Liverpool School of Tropical Medicine (LSTM).



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SEPSIS: A SILENT KILLER AFFECTING BLANTYRE'S YOUNG PEOPLE AND PREGNANT WOMEN

Paul Kawale PhD.

The World Health Organization (WHO) declared COVID-19 a pandemic on March 11, 2020. All the continents except Antarctica have so far reported thousands of coronavirus cases and/or deaths. Globally, more than a million cases have been reported with 24% of deaths affecting a broad range of ages. Africa has been lucky to have a delayed onset of the spread of COVID-19. The continent has had the benefit of time to learn from measures and contingencies that are working in other countries. However, there is need to take caution not to generalize and mirror policies being implemented in other places without consideration of Africa's unique context i.e. demographic structure, population, disease burden health care systems, and living conditions.

Globally, coronavirus has spread rapidly and countries are using various measures to curb the pandemic disease. These measures include complete and/or partial lockdowns, shifting to remote working, online schooling, promoting hand-washing, and social distancing. Seemingly, many countries have adopted lockdown policies where majority of citizens are advised to stay home and prepare for what could be months of isolation and social distancing. However, some of the recommended measures are not practical in the African setting because of various reasons. For instance, a significant populace lives from hand-to-mouth relying on daily wages, and total lockdown means no food. Also, Internet access is so limited that working remotely or online schooling is not possible for majority of the population.

COVID-19 could bring Africa's weak health systems to their knees

In ealry April, the Coronavirus had spread to just 39 African countries, reaching 8000 recorded cases and 334 deaths. As of May 13, every country in Africa had recorded a case, to date the continent has over 780,000 cases and over 16,000 deaths. There were concerns that the absence of cases was a result of lacking or weak testing capacity. WHO has been supporting African governments with early detection by providing COVID-19 testing kits, training health workers, and strengthening surveillance in communities. As of April, 47 out of 54 countries in the WHO African region could test for COVID-19, now all countries can conduct tests.

Early detection of cases is one of the measures of curbing the spread of coronavirus as it allows coronavirus-infected patients to be separated from non-infected people.

Experts are worried about COVID-19 rapidly spreading in Africa and numbers rising to those recorded in countries such as China and Italy previously and now the United States, Brazil and South Africa. A major concern is the fragile health systems in most African countries that often suffer from minimal or no medical supplies and equipment, inadequate funding, shortage of adequately trained healthcare personnel, and inefficient data transmission and use. These weak health care systems are currently overburdened by diseases such as malaria, HIV, tuberculosis, cholera, cancer, diabetes, and maternal and child health issues. Clearly, these systems currently have no capacity to deal with COVID-19. Experts therefore fear that the pandemic could be difficult to manage in Africa, and could cause huge numbers of deaths and grave economic problems if it spreads widely.

African countries must learn from own experiences of managing Ebola, polio and cholera

In the last three years, Africa has had significant experience having dealt with different epidemics like Ebola, polio and cholera. Hence, drawing lessons learnt on preparedness and response to previous epidemics is crucial in enabling African countries develop effective strategies to curb the spread of COVID-19. For example, there is undocumented evidence that Taiwan and Singapore took quick drastic measures to curb COVID-19 due to their experience with Severe Acute Respiratory Syndrome (SARS). Active surveillance network, among other, measures helped to control and prevent massive spread of the disease epidemics in their countries. Documenting evidence on the lessons from African countries that experienced and addressed Ebola could also be valuable in designing country responses to COVID-19.

A strategic approach is critical for African governments to combat this COVID-19 pandemic. For Africa considering her unique context, the strategy should focus on prevention and containment. Indeed, African governments can borrow valuable lessons from other countries who had earlier exposure with coronavirus such as Italy and China.

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