



The Dilemma of African Countries in the Management of Covid-19 Pandemic

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Abstract

African countries under the African Union have developed a framework for eradication of preventable diseases and the promotion of good health on the continent. At the outbreak of coronavirus in 2019 and its widespread to every part of the globe, African countries were affected. Collectively and individually, African States began to develop strategies to fight against the wide spread of the disease in the continent. Prominent of the strategies were the formation of presidential Task Force on COVID-19, ensuring Lockdown Practices, building quarantine centres, etc. However, these practices were found to be exogenous and therefore alien to the people of African. Further, the manners which they were enforced contradicted the world best practices, including the fundamental human rights of the citizens. Besides, the sincerity of the Government in the pursuit of the strategies was questionable. These made African States to be in the dilemma of combating the coronavirus pandemic.

Introduction

Rebuilding the Pan-Africanism from the ashes of the Organization of African Unity (OAU) spurred the formation of African Union (AU), which was formerly launched in July 2002. The Constitutive Act and the Protocol on the Amendments of the Constitutive Act of the Union laid out the aims of the AU, which among others, is to work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent. To actualize this laudable objective, the Union and its independent member countries are expected to put every effort in place to make it a reality. That was why against the backdrop of the eruption of Ebola crisis in Africa in 2014, the African Union Heads of State and Government recognised the need for a Specialized Agency to support AU member states in their efforts to strengthen public health systems and to improve surveillance, emergency response and prevention of infectious diseases. This resulted in the launch of the Africa Centres for Disease Control and Prevention (Africa CDC) in January 2017. Along with the European Centre for Disease Control and Prevention, Africa CDC is the first public health institute mandated to harmonise infectious disease surveillance and control among a group of African independent countries. It was expected that from 2017 – 2022, the Africa CDC would work with member states, World Health Organisation (WHO), and other partners to strengthen its capacity in four strategic priority areas: (1) health-related surveillance and innovative information systems, with a focus on improved capacity for event-based surveillance, disease prediction, and improved

public health decision making and action; (2) functional and linked clinical and public health laboratory networks in the five geographic sub-regions of Africa; (3) support for member states' public health emergency preparedness and response plans; and (4) strengthened public health science for improved decision making and practice (Nkengasong, Maiyegun & Moeti, 2017). To ensure capacity to implement these strategic priority areas, the Africa CDC would develop innovative programmes in the areas of competency-based workforce development, partnerships, financing of public health activities, and communication among member states. This approach would support African countries to achieve existing international health targets, including the Sustainable Development Goals, the International Health Regulations (IHR), and universal health coverage.

Following the coronavirus outbreak in Wuhan, the capital and major business city of Hubei province, China, in late December 2019, (COVID - 19), previously known as 2019- novel coronavirus (2019-nCoV) and its spread to parts of Asia, Europe, the Middle East and the United States of America, Africa seems to have been spared of a major outbreak for months, recording its first confirmed case only on 14 February, 2020 in Egypt. Though Africa has close ties with China, its risk of importation of COVID-19 based on travel exposure to China is lower compared to Europe and Americas. On the whole, the global effect of COVID-19 has become so devastating that the World Health Organisation on March 11, 2020, declared the coronavirus a pandemic. The pandemic has spared no continent of the world including Africa. This therefore forced African countries to swing into

action by mapping out workable strategies to combat the spread of the pandemic.

Risk Factors in the Spread of COVID-19 in African Countries

As the pandemic continued to spread in Africa, the Mo Ibrahim Foundation (Undated:7 provided a chart

of possible enabling risk factors for the spread of covid-19 across African countries. The Countries were categorized by relative risk for each factors on a scale from 1 -5, with 1 as the less risk, and the level of risk progressed mathematically till 5, which is the most risk level. The chart is a shown in the table below.

Table 1: Composite Country list of key Risk Factors

Country	Int'l Exposure	Pub. Health System	Density of Urban Areas	Total Pop.in Urban Areas	Pop Age	Govt's Transp arency	Press Free dom	Conflict Magnitude	Forced Displacement	Risk Total (out of 45)
South Sudan	2	5	5	3	2	5	5	5	5	37
DRC	3	5	3	5	1	5	4	5	5	36
Nigeria	5	5	2	5	2	4	3	4	5	35
Sudan	3	3	4	4	2	5	4	5	5	35
Cameroon	3	4	3	3	2	4	5	3	5	32
Egypt	5	1	3	5	4	3	4	2	4	31
Ethiopia	3	3	4	5	2	2	4	3	5	31
CAR	1	5	3	2	3	4	4	4	4	30
Somalia	1	5	1	2	2	5	4	5	5	30
Libya	3	3	1	2	4	5	4	4	4	30
Chad	1	5	5	3	1	5	4	1	4	29
Equatorial Guinea	4	5	3	1	3	5	5	1	1	28
Uganda	3	2	4	4	1	4	4	1	4	28
Algeria	4	1	2	4	5	3	4	1	3	27
Angola	3	4	4	3	1	4	4	1	3	27
Cote d'Ivoire	4	4	2	3	3	3	3	1	3	27
Mali	2	5	4	3	1	3	3	2	4	27
Morocco	5	1	3	4	5	2	4	1	2	27
Mozambique	4	4	3	3	1	4	3	2	3	27
Rep. of Congo	3	3	4	2	2	5	4	1	3	27
Burkina Faso	2	4	3	3	2	2	3	3	4	26
Burundi	1	3	3	2	2	5	5	2	3	26
Djibouti	1	4	4	1	4	3	3	1	3	26
Kenya	4	2	1	4	3	4	3	1	4	26
Tanzania	3	3	3	4	2	2	4	1	4	26
Mauritania	1	4	4	2	3	4	3	1	3	25
Niger	1	4	4	3	1	3	3	2	4	25
South Africa	5	2	1	4	5	1	2	1	4	25
Togo	3	4	3	2	3	3	3	1	2	24
Zambia	3	3	3	3	1	3	4	1	3	24
Zimbabwe	3	2	2	3	3	4	4	1	2	24
Guinea Bissau	1	4	4	1	2	5	3	1	2	23
Madagascar	2	3	3	3	3	4	3	1	2	23
Senegal	2	3	5	3	2	1	3	1	3	23
Comoros	1	4	3	1	3	4	4	1	1	22
Eritrea	1	2	2	2	3	5	5	1	1	22
Guinea	2	5	2	2	2	3	3	1	2	22
Ghana	3	3	2	3	3	2	2	1	2	21
Liberia	2	4	1	2	2	4	3	1	2	21
Rwanda	2	2	2	3	2	1	5	1	3	21
Tunisia	4	1	2	2	5	1	3	1	2	21
Eswatini	2	3	1	1	4	3	4	1	1	20
Gabon	3	2	2	1	3	3	4	1	1	20
Lesotho	2	5	1	1	4	2	3	1	1	20
Sierra Leone	1	5	2	2	2	3	3	1	1	20
The Gambia	2	3	3	1	3	2	3	1	2	20

Malawi	2	3	1	2	1	3	3	1	3	19
Botswana	4	2	1	1	4	1	3	1	1	18
Namibia	4	2	2	1	3	1	2	1	2	18
Benin	1	4	2	2	1	2	2	1	2	17
Cabo Verde	2	1	4	1	5	1	1	1	1	17
Mauritius	3	1	1	1	5	1	2	1	1	16
Seychelles	2	1	1	1	5	1	3	1	1	16
Sao Tome and Principe	1	1	3	1	2	1	2	1	1	13

Source: Mo Ibrahim Foundation (u d) Covid-19 in Africa: A call for Coordinated Governance, Improved Health Structure and Better Data: <http://mo.ibrahim.foundation/files>.

Africa appears to have comparative advantages over Western and Eastern countries when it comes to COVID-19. One of the advantages is the demography of Africa. African population is the youngest in the world, with a median age of less than 20, and it currently seems that the younger the population, the milder the effect on the people. Hence, the older people have significantly higher risk of contracting severe symptoms. On this note, Mo Ibrahim foundation (undated: 8) asserts that early data from China suggest that a majority of coronavirus deaths have occurred among adults aged 60 years and above and persons with serious underlying health conditions, and that only 3% of sub-Saharan Africa's population is older than 65, compared with about 12% in China. Mo Ibrahim foundation further stated that another advantage could be related to its climate. Among the several environmental factors that influence the survival and spread of respiratory viral infections, air temperature plays a crucial role. In tropical climates, influenza and respiratory viruses are transmitted mostly during the cold rainy seasons. Despite COVID-19 being relatively new to have reliable data on its spread, it is possible that it will follow the same pattern. Also, there is currently marked temperature differences between the most affected (colder) and least affected countries (warmer) in the COVID-19 pandemic.

The above risk factors reflected on the share of African countries in contacting the Covid-19 pandemic, the number of cases fluctuating on daily/hourly basis. The breakdown of the number of cases among the 54 African countries is as shown in table two below

Table 2: Coronavirus Cases by African Countries

Country	Confirmed cases	Deaths	Recoveries
Algeria	7728	575	4, 062
Angola	60	3	18
Benin	135	3	61
Botswana	29	1	19
Burkina Faso	812	52	669
Burundi	42	1	20
Cameroon	3529	140	1567

Cape Verde	356	3	95
Central African Republic	436	0	18
Chad	588	58	186
Comoros	34	1	8
Congo, Republic	469	16	137
Congo, Democratic Republic	1945	63	312
Cote d'Ivoire	2301	29	1100
Djibouti	2047	10	1055
Egypt	15003	696	4217
Equatorial Guinea	719	7	22
Eritrea	39	0	39
Eswatini	220	2	112
Ethiopia	399	5	123
Gabon	1567	12	365
The Gambia	24	1	13
Ghana	6486	31	1951
Guinea	3067	19	1575
Guinea-Bissau	1109	6	42
Kenya	1109	50	375
Lesotho	1	0	0
Liberia	240	23	131
Libya	71	3	35
Madagascar	405	2	131
Malawi	72	3	27
Mali	947	60	558
Mauritania	173	5	6
Mauritius	332	10	322
Morocco	7211	196	4280
Mozambique	162	0	48
Namibia	18	0	14
Niger	924	60	753
Nigeria	7016	211	1907
Rwanda	320	0	217
Sao Tome and Principe	258	11	7
Senegal	2812	33	1251
Seychelles	11	0	11
Sierra Leone	585	35	205
Somalia	1594	61	204
South Africa	19137	369	8950
South Sudan	282	4	4
Sudan	3138	121	309

Tanzania	509	21	167
Togo	354	12	118
Tunisia	1046	47	883
Uganda	289	0	66
Zambia	866	7	302
Zimbabwe	51	4	18

Source:<https://www.cnbcafrica.com/africa-press-office/2020/05/22/coronavirus-african-union-member-states-reporting-covid-19-as-of-may-2020-9am-eat>.

Managing Covid-19 in Africa

The emergence of the COVID-19 pandemic, its spread and stress in some of the world's most advanced health systems has left fears on Africans on how the continent with its or her weak public health institution can manage the pandemic. This fear is further hinged on the obvious presence of high levels of poverty, urban density, and overcrowded informal settlements, which Africa faces as preponderance risk factors that threaten to exacerbate the pandemic on the continent. Given these challenges, many African countries, without considering their peculiar circumstances, especially over reliance of majority of the population on subsistence livelihoods, level of Government respect for fundamental human rights, etc, followed the global trend of imposing shutdowns of businesses, schools and inter-state human movements, even at the time the pandemic cases were at very low ebb, as solution measures. Outside the global measures, it is necessary that Africa's response to the pandemic should be customized to its own realities, challenges, resources, and strengths. In an effort to grapple with the pandemic and domesticate the strategies, a number of adaptations to the coronavirus response in Africa have been unfolded, which however are seen to have followed "the me too can do it syndrome", and which are signs of dependency on the West. Some of these strategies are:

1. Establishment of Presidential Task Forces

Many African countries have established presidential COVID-19 task forces, consisting of public health and sectoral experts as an institutional innovation to guide the pandemic response. The central role of professionals in these task forces has elevated the emphasis on science and evidence-based planning. In Uganda, a Presidential Scientific and Strategic Advisory Committee assembled economists, anthropologists, epidemiologists, public health experts, virologists, and lawyers to design and deliver an effective approach addressing various facets of the crisis (Africa Center for Strategic Studies, 2020). The prominence of the members of these presidential task forces has facilitated the absorption of lessons and experiences from other

parts of the world as well as from African Epidemiology Association and the Royal College of Pathologists, placing African countries in a better position of understanding the nature of the pandemic, its challenges, and myths. The result has been an aggressive effort to mount tailored and scientifically and culturally sound public health actions, aimed at preventive interventions, rather than relying on a therapeutic approach that would overwhelm the limited treatment options at Africa's hospitals. The presidential task forces are also drawing on Africa's extensive experience in pandemic outbreaks, using lessons from the 2014 West Africa Ebola outbreak. For instance, the Nigerian government quickly set up isolation clinics separate from the regular health system to treat coronavirus patients. The idea is to avoid inundating the established health system so that it can continue serving other pressing needs such as malaria, tuberculosis, and HIV/AIDS, etc, within the population. The Nigerian Presidential Task Force on COVID-19 was established by the President on March 17, 2020, to coordinate and oversee Nigeria's multi-sectoral inter-governmental efforts to contain the spread and mitigate the impact of the COVID-19 pandemic in Nigeria. Specifically, the responsibilities of the Task Force as put by the PTF (2020), which was put in place in many African countries include:

- develop guidelines and best practices for COVID-19 response
- reduce COVID-19 related morbidity and mortality
- mitigate pandemic-related impacts on critical, economic and health infrastructure
- facilitate post-pandemic recovery and rehabilitation operations

2. Lockdown Practices

Many African countries also enforced lockdown of social activities, including religious, economic and educational activities at the spread of COVID-19 in Africa. This is why de Waal and Richards (2020) stated that many African governments hurriedly implemented lockdowns when the COVID-19 outbreak hit their countries. This is enforced through collaboration with other agencies such as the Police, Army, Civil Defence Corps, etc. The interagency coordination fostered by these task forces has created opportunities to address the role of the security forces in creating conducive environment for responding to the pandemic. This scenario was captured by the Africa Center for Strategic Studies (2020) when it stated that in Uganda, the military police were tasked with

monitoring soldiers to ensure that stay-at-home orders were implemented humanely. This was after public complaints about harassment by local defense units enforcing the lockdown. In South Africa, the behaviour of the security forces during the state of emergency was monitored by the Independent Police Investigation Directorate. In Nigeria, the police and men of the Civil Defense, and at times, the military, were used to ensure compliance to the lockdown order.

The strategy of curtailing the spread of the pandemic did not go without hitches, given Africa's high levels of poverty as many people were endangered in starvation and the depletion of coping mechanisms, particularly among the most vulnerable. Clashes between citizens defying movement restrictions and security forces have led to deaths and injuries in Nigeria, Rwanda, South Africa, and Uganda. For instance, in Nigeria it was enforced in such ways that people's freedom of movement was infringed upon. The Human Right Watch (2020:23) made a report on the matter. The report shows that 27 incidents of violation of right to movement, unlawful arrest and detention were recorded within the period. Lagos State recorded the highest number of cases with 8 incidents followed by FCT, Abuja with 6 incidents and Enugu State with 5 incidents. Gombe recorded 3 incidents; Imo and Rivers State recorded 2 incidents each, while Benue recorded 1. The report shows that out of the 27 incidents, 90 -95% were allegedly perpetrated by officials of the Nigeria Police Force, while about 3% were perpetrated by Nigeria Army. The report further shows that Non-State Actors such as vigilante groups and private persons also violated the right to freedom of movement and indulged in unlawful detention. This is evident in the Enugu incident where construction workers allegedly locked up policemen who came to arrest them thereby preventing the policemen from leaving the premises.

Besides, for a majority of Africans who eat from hand to mouth and cannot afford to stock food even for two days, lockdown translates to starvation (Nderitu 2020). Unlike governments in developed countries, most governments in Africa could not afford to feed so many poor families sustainably and the risk of dependence after COVID-19 is real (De Waal and Richards 2020). COVID-19 is merely worsening a bad situation: before lockdown was implemented, some Kenyan families were already begging for food. With the familiar horror of starvation, gambling with COVID-19 with its relatively small mortality rate, (de Waal and Richards 2020) can make more sense.

Fundamentally, the Task Force, the establishment of the isolation centre and the lockdown system adopted in African countries cannot be said to be indigenous of the continent. The isolation of infected person(s) is the recommendation of the World Health Organisation. This corroborated by Waya, Ameh, Mogga, Wamala & Olu (2021:2) when they put that the World Health Organisation (WHO) recommends that all laboratory-confirmed cases should be isolated and treated in a health care facility

3. Building Isolation Centres and New Hospital Wards

In the height of COVID-19, developed countries responded to the crisis by building special isolation centres and new hospitals. China, from where the pandemic started built a one thousand-bed facility in less than two weeks. Other developed countries equally built isolation centres, however, did not record similar success. United States of America and Italy, for example, ran short of the demand for COVID-19 management facilities. The experiences from these two developed countries sent fear to African countries whose healthcare systems are already overwhelmed by high disease burden, inadequate facilities, under-staffing, and lack of equipment among other challenges (Nderitu and Kamaara, 2020). The COVID-19 further exposed Africa's challenges in the health systems, which is characterizes by huge deficits of basic materials like testing kits, personal protective equipment, and equipment for assisted breathing (de Waal and Richards 2020). By mid-April, according to Maclean and Marks (2020) ten of the fifty-four African countries did not have a single ventilator. Others had one ventilator for almost every three million people as in South Sudan, with eleven million people, had only four ventilators (Ajack 2020). African countries have to re-think strategies for COVID-19 prevention and management.

4. Quarantine

Both self and forced quarantine of COVID-19 infected or suspected cases help in the control of the spread of COVID-19. However, the effectiveness of quarantine depends on how well it is implemented. Nderitu (2020) gave an elaborate situation of quarantine condition in Kenya. He gave a narrative that in Kenya, as in many African countries, those facing mandatory quarantine decried the pathetic conditions in government isolation centres. Hygiene was poor and people interacted freely within the centres exposing those who were not infected to infection. Quarantine then worked against its very

purpose by becoming a weak link in COVID-19 prevention.

5. Neglect of Indigenous Medication

In Africa, traditional medicine is culturally entrenched, accessible, and affordable, and serves as primary source for healthcare to a great number of the population across the continent. This practice capitalizes on the rich biodiversity (plants and herbs) and effectively balance the relationship between man and nature, as well as indigenous knowledge passed on through generations. This made many African people to be in close relationship with traditional medicine.

At the widespread of COVID-19, Madagascar's President Andry Rajoelina announced that the country had discovered a cure and treatment for COVID-19. The announcement pushed African interest in the potential that such remedies may have and the dangers that untested cures may carry. Since the announcement, Madagascar has continued to use what's known as COVID-Organics, or CVO, in tea and pill form in its fight against COVID-19 and exported it to other African countries, including Equatorial Guinea, Guinea-Bissau, the Republic of Congo, and Tanzania. In a bid to enhance research and development of traditional medicines like CVO, the World Health Organization (2020) and the Africa Centres for Disease Control and Prevention established a Regional Expert Committee on Traditional Medicine for COVID-19 in July 2020, hoping to test traditional therapies and provide independent advice about their safety and efficacy. But six months after its formation, it appears that this attempt to regulate has failed to gain traction: None of the proposed remedies has yet progressed beyond phase II clinical trials. The African political leaders neglected the African traditional medicines and look up to the West for whatever they produce in the fight of the pandemic. This is in spite of Africa's capacity to consolidate the knowledge that is available on the continent to provide traditional medical therapies that are affordable and safe for public health, including COVID-19.

6. Targeting Vulnerable Populations

Innovations have also been implemented to support those households most vulnerable to restrictions on mobility and the economic hardships this creates. Helping them to meet basic livelihood needs such as access to food can reduce the threat of spread in Africa's many sprawling urban informal settlements where COVID-19 could spread like wildfire due to massive congestion, poor hygiene, and preexisting health conditions. The U.S.-based Ethiopia Diaspora Trust Fund provided a \$1 million start-up fund to assist COVID-19 mitigation efforts

in Ethiopia, including food assistance and direct cash transfers to vulnerable families.

In Kenya's informal settlements of Kawangware, Mathare, and Majengo, indigenous organizations such as Mutual Aid Kenya, Sarafu Credit, the Kenya Red Cross Society, and Zakat Kenya are reinforcing the government's response strategy by identifying vulnerable families and providing targeted assistance through direct cash transfers, food parcels, and alternative supply chains to provide essential commodities. Sarafu Credit is using a block-chain-backed system of community currencies (credit vouchers) that communities in informal settlements can use to purchase food and other essentials (Nderitu, 2020). In Kibera, the largest of these settlements, a community run organization called Shofco has established hand washing stations, community toilets, and clean-water kiosks in all access points, staffed by volunteers and a network of health workers. Well over half of the population of the settlement —139,000 people— have subscribed to a WhatsApp platform that provides information about the virus, the patterns of infection in Kibera, and what they should do to protect themselves and the community. Three thousand of the area's most vulnerable families are receiving a direct cash transfer of \$24 per month for 3 months to meet their basic needs, with financing coming from the local private sector and the Kenya diaspora in North America. These efforts are modeled on a Kenya government pilot initiative implemented during the 2009-2010 drought that provided \$20 per month to 40,000 families in informal settlements for 9 months to meet their basic food needs.

In Botswana, a wage subsidy totaling 1 billion pula (\$84 million) has been provided to small businesses as an incentive to retain their employees during the shutdown. In addition, the government will contribute 50 percent of the basic salary of every furloughed citizen or permanent resident for 3 months, along with a subsidy of 1,000-2,000 pula (\$80-\$168) per month to meet basic needs.

Though this strategy was adopted, the real vulnerable are not captured. In Nigeria, for instance, the nation's leader, President Mohammad Buhari, announced an expansion of the initial number of households that would benefit from the direct distribution of food and cash from 2.6 million households to 3.6 million households, whom he described as most vulnerable in the society. He, therefore, directed the Ministries of Industry, Trade and Investment; Communication and Digital Economy; Science and Technology; Transportation; Interior; Health; Works and Housing; Labour and

Employment; and Education, to jointly develop a comprehensive policy for a Nigerian economy functioning with COVID-19 pandemic.

There are, however, lamentations trailing the distribution of government palliatives by the masses. For instance, a national newspaper, Business Day (April 19, 2020), reported thus: "It is lamentation and bitter wailing in Lagos and parts of the country as Nigerians complain that the stimulus packages announced by the Federal and Lagos State governments to cushion the effects of the lockdown imposed on some States and the Federal Capital Territory to contain the further spread of the coronavirus (COVID-19) pandemic have not been sincerely deployed." According to the newspaper, the citizens alleged that the process of distribution of whatever that may have been made available for that purpose had been politicized.

It could be recalled that the Federal government of Nigeria had earlier said the palliatives were for the most vulnerable in the society, though there were no laid down parameters for determining the most vulnerable. For example, in Edo State, most of the residents claimed they were not aware if there was any distribution of palliatives in their localities. They alleged the palliatives were hijacked by politicians who now turned themselves to be vulnerable. The state's leadership borrowed a leaf from the federal government by saying that the palliative packages were for the most vulnerable. The questions that loomed large and which both the federal and state governments are unable to answer is: who are these vulnerable people? Is it that the federal government was unable to evolve a transparent process to ensuring fair distribution of the palliatives? Is the idea of undefined vulnerability a ploy by the governments to hijack the palliatives for their party faithful? What about those people that lost their jobs or income, are they to be regarded among the most vulnerable? Vulnerability in the common sense is when an individual is unable to cater for himself/herself or family as a result of a prevailing situation he/she is being faced with.

7. Combating Misinformation

As COVID-19 continues to spread around the world, rumor, misinformation, and fake news about the pandemic spread also. Videos, voice messages, texts, and stories have swirled around conflicting information, from unproven cures to bizarre claims that Africans are somehow immune from COVID-19, despite an abundance of contrary evidence. Africans are reacting to the challenge in different ways. In South Africa, a private firm, Praekelt.org, created a WhatsApp-based helpline that provides real-time data and automated responses in numerous

languages to educate and sensitize. The app registered 3.5 million subscribers within the first 10 days of launching. Praekelt.org has now partnered with the World Health Organization to create a similar service to reach a global audience. In Southern Africa, exchange of information was conducted through a Regional Technical Committee established by the Southern African Development Community (SADC), consisting of the directors of public health and medical services of member states.

The Nigerian Presidential COVID-19 Task Force has also established a 24-hour hotline providing up-to-date information to inform and protect the public from misinformation and rumors. Many presidents and senior health leaders are also using their daily briefings to dispel rumors and misinformation about COVID-19.

Nonetheless, the information management strategy adopted by African countries is to say the least, ineffective to control the spread of COVID-19. This is because there are variations of information regarding to the pandemic, which has caused many families to hinge to numerous information depending on who they see as their data base. That is why Nderitu and Kamaara (2020:2) aptly stated that in contexts where families cannot afford reliable sources of information, social distancing may be counterproductive. Close social ties may be the only way through which reliable information, in this case on COVID-19, is communicated.

Conclusion

Africa continues has faced an uphill battle against COVID-19, given its limited resources, fragile health systems, existing disease burden, urban density, conflict, and record levels of population displacement. Nonetheless, African governments and societies have demonstrated a noteworthy level of responsiveness, cooperation, and adaptability to the pandemic. The adaptation of inter-sectoral presidential task forces composed of leading scientists and practitioners has created a high-level platform to harness Africa's hard-earned expertise in combating public health crises. Operating with presidential authority has accelerated decision-making for many governments while reducing interagency squabbles. However, it is astonishing to note that most of the strategies adopted by African countries in the fight against COVID-19 are foreign driven. The continent follows copycat strategies which are pasted on African environment that never met the domestic experiences and inclinations. To this effect, the strategies are either resisted or not complied with by the citizens of different African States. Alternatively,

therefore, African countries should look inward to apply traditional medications, which Africans are used to and which have the potency to handle the ailment.

References

- Africa Centres for Disease Control and Prevention (2020). Retrieved from (<https://www.devex.com/organizations/centres-for-disease-control-and-prevention/africa-cdc-120577>.)
- African Centre for Strategic (2020). *African Adaptations to the COVID-19 Response*, *Spotlight*, April 15.
- Ajack, M. (2020). *South Sudan becomes the 51st country in Africa with COVID-19 as it confirms its first case*. *Time*, April 5. Retrieved from <https://time.com/5815838/south-sudan-africa-coronaviruscovid-19>.
- BusinessDay (2020). Retrieved from <http://lamentation-still-trails-lagos-fgspalliative-packages-as-middlemen-hijack-programme/amp/>.
- de Figueiredo A.M., A.D. Codina, D.C.M.M. Figueiredo, M. Saez & A.C. Leon. (2020). *Impact of lockdown on COVID-19 incidence and mortality in China: An interrupted time series study [Pre-print]*. *Bulletin of the World Health Organization*. E-pub: April 6. Retrieved from <https://doi.org/10.2471/BLT.20.256701>.
- deWaal, A., & P. Richards. 2020. *Coronavirus: Why lockdowns may not be the answer in Africa*. *BBC News*, April 15. Retrieved from <https://www.bbc.com/news/world-africa-52268320> <https://www.cnbc.com/africa-press-office/2020/05/22/coronavirus-african-union-member-states-reporting-covid-19-as-of-may-2020-9am-eat>.
- Maclean, R., & S. Marks. (2020). *10 African countries have no ventilators. That's only part of the problem*. *New York Times*, April 18. Retrieved from <https://www.nytimes.com/2020/04/18/world/africa/africa-coronavirus-ventilators.html>.
- Mo Ibrahim Foundation (u d) *Covid-19 in Africa: A call for Coordinated Governance, Improved Health Structure and Better Data*: Retrieved from <http://mo.ibrahim.foundation/files>.
- Nderitu, D & Kamaara, E (2020). *Gamling with COVID-19 makes more Sense: Ethical and Practical Challenges in COVID-19 Responses in Communalistic Resource-Limited Africa*, *Journal of Bioethical Inquiry* Pty Ltd, pp 1-5
- Nderitu, D. (2020). *Coronavirus poses ethical concerns: A view on the choices being made in Kenya*. *The Conversation*, April 22. Retrieved from <https://theconversation.com/coronavirus-poses-ethicalconcer ns-a-view-on-the-choices-being-made-in-kenya-135338>.
- Nkangasong, J, Maiyegun, O, & Moeti, M. (2017). *Establishing the African Centre for Disease Control and Promotion: Responding to Africa's Health Threats*, *The Lancet Global Health* 5 (3).
- Waya, J. L.L; Ameh, D; Mogga, J. L.K; Wamala, J.F; & Olu O. O (2021). *COVID-19 Case Management Strategies: What are the Options for Africa? Infectious Disease of Poverty* 10(30) pp 1-6.
- World Health Organization (2020). Retrieved from <https://www.devex.com/organizations/world-health-organization-who-30562>.