Review of: "Post-Pandemic Reflections from Sub-Saharan Africa: What We Know Now That We Wish We Knew Then"

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This article speaks to a fundamental lesson learned from COVID-19, namely, that context matters. As briefly mentioned in the article, a contextual factor such as average age played a crucial role in relation to the reduced impact of SARs CoV-2 on hospitalisations and mortality. In Africa, the average age is 18, making wholesale lockdowns largely unnecessary but also hugely damaging. Moreover, the lower population age makes mass mandatory vaccination, in order to achieve 70% vaccinated targets (as first suggested by the WHO), untenable on both economic and public health grounds. COVID-19 vaccines are expensive (if you could get them), do not prevent transmission, and are simply unnecessary for a vast majority of young people. Where pharmaceutical and non-pharmaceutical efforts should have focused is on the highly vulnerable and those over 70 years of age. That would have saved money, saved lives, and also saved a majority of us from social and economic hardship.

The article also rightly suggests the need for the better use of evidence. Yet, this is tricky. Unfortunately, reliable evidence on SARs CoV-2 was scant in the first two to three months of the pandemic, with considerable contestation between health professionals lasting well into the second year of the outbreak. In the beginning, many governments simply ‘cookie-cut’ policies from other countries with the assumption that those countries knew what they were doing and/or out of ‘an abundance of caution’. Politicians had to do something, and there was increasing social and media pressure. This resulted in oddly similar policies for lockdowns, mask mandates, school closures, travel restrictions, and social distancing measures; several of which had no public health track record (as pointed out in the article).

However, by cookie-cutting policy, context was not appropriately considered, while evidence bases were also assumed to have been appropriately vetted elsewhere. Countries that behaved differently, like Sweden, were named and shamed, with some public health professionals arguing that the Swedish government was equal to ‘mass murderers’. This added further pressure on policymakers to do something quickly and to not be labelled as ‘killers’, while also signalling the need for sceptical health professionals to keep silent. It also led to an overreliance on the private sector to ‘bail us out’, leading to rushed and questionable conflicts of interests, as well as products. What this suggests is that the separation of evidence from politics is not only impossible, but would be reliant on the existence of solid evidence and the meaningful deliberations required to verify that evidence base. It is here where key lessons must be learned, and where WHO simplicities like ‘preventing infodemics’ might actually generate counterproductive evidentiary rabbit holes.

As the article suggests, a key component in pandemic preparedness will be making sure that processes for reliable evidence-based policy making are put in place prior to any health emergency, that health systems are robust and have

adaptive capacities, that community-level approaches are adopted (beyond just surveillance), that context is considered, and that rational procedures are not forgotten when fear threatens to override reasoned discussion. This is not just a lesson for Africa, but globally as well.