AUDA - NEPAD
AFRICAN UNION DEVELOPMENT AGENCY

COVID-19 Digest

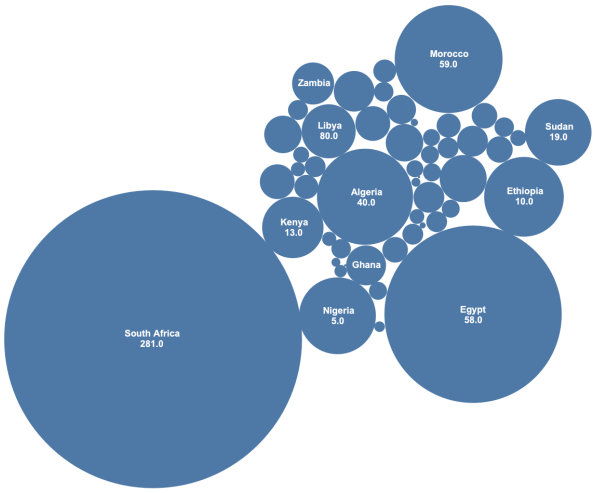
Weekly issue 001-2020

CONTENTS

Cumulative COVID-19 cases in Africa among 55 AU Member Countries, September 30, 2020

At the end of September 2020, out of the 34 million confirmed COVID-19 cases worldwide, Africa accounted for 4% (1.48million cases). Approximately seventy percent (70%) of these cases in Africa were confirmed in five countries- South Africa, Morocco, Egypt, Ethiopia and Nigeria. Likewise, these five countries accounted for 75% of the total COVID-19 related deaths among the 55 AU member states.

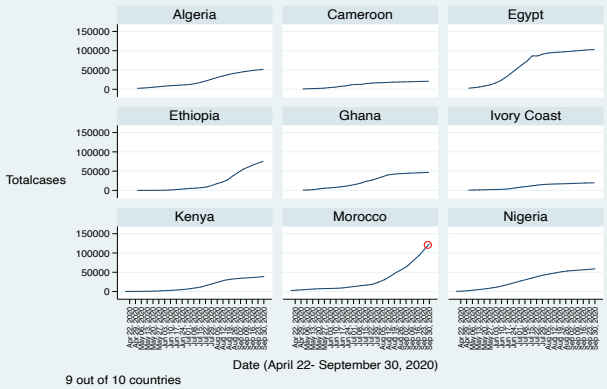
Deaths per 1 million Population from COVID-19 Among 55 AU Member States, September 30, 2020



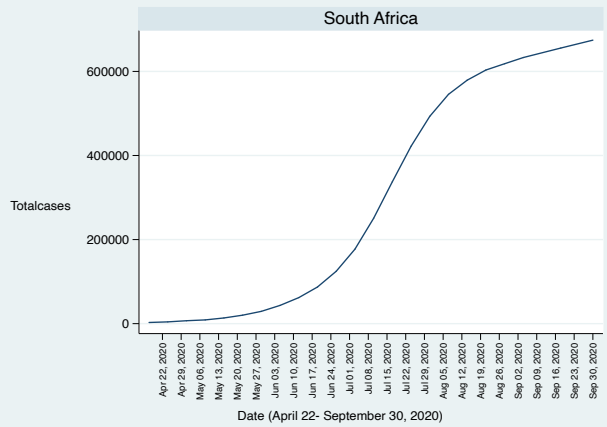
A review of the deaths per 1 million inhabitants shows the top seven countries include South Africa (281 per 1 million population), Libya (80), Morocco (59), Egypt (58) and Algeria (40). When compared to global average of 130.6 deaths /1million population, South Africa ranks high, but pales in comparison to countries with highest confirmed cases such as United States and Brazil (676 and 639 deaths per 1 million population respectively).

© All graphs are originally generated using official data collated by Worldometer and analyzed by Health Maxima, LLC for AUDA-NEPAD

Trend of COVID-19 cases Among Top 10 Countries with Highest Number of Cases (April 22-Sept 30, 2020)



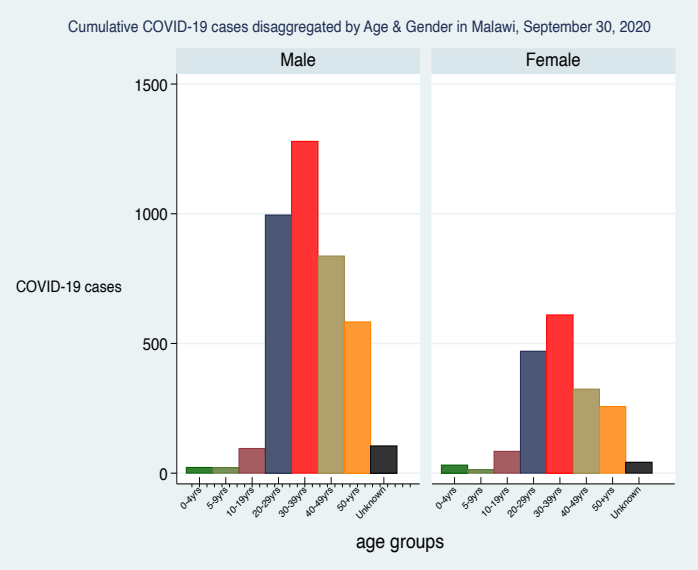
9 out of 10 countries



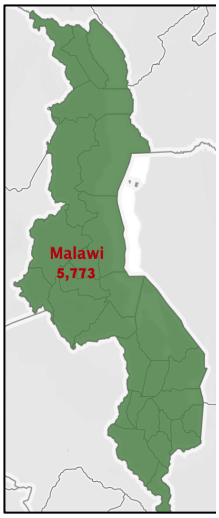
By September 30th, 2020, increasing trends are observed for Morocco and South Africa while a plateau is noted in the other eight countries.

In this edition of the digest, as the limelight is cast on Malawi and Mauritania on how COVID-19 impacts on age and gender; it is evident and suggests that it is '***time to protect our men'***.

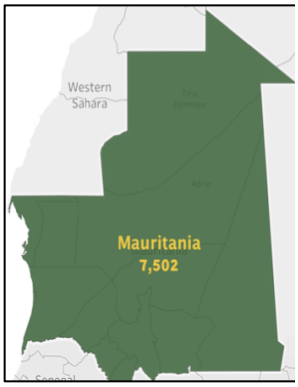
Malawi



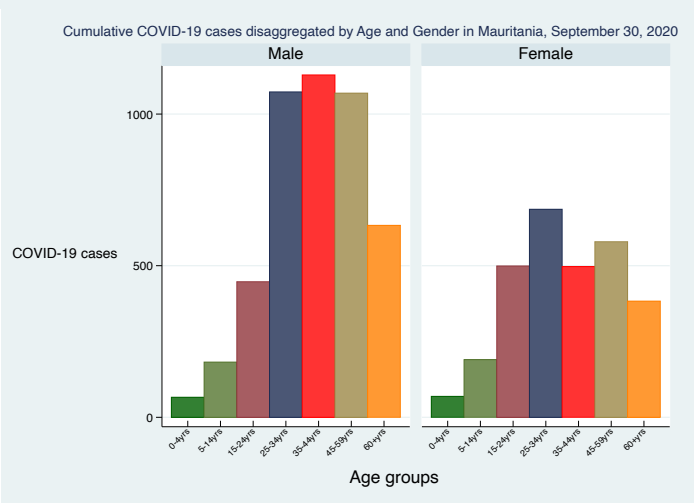
In concordance with global data, the cumulative COVID-19 cases at the end of September 2020 was higher among men compared to women, with 67% of cases observed among men and a Male: Female ratio of 2:1 especially in ages 20-39 years and ages ≥ 50years (dark navy, red and orange bars), and 2.5-3 times higher among men in ages 40-49years (brown bars) compared to women. This in effect indicates the impact of the virus on the productive male workforce and economic scale, while also providing a guide on the target group Malawi should direct its strategies and efforts in order to break the chain of transmission.



Mauritania



Among its 7,502 cases confirmed on September 30, 2020, approximately 61% of its cases were detected among men. On average, equal rates ranging from 14.2 - 15% were observed in age groups 25-34, 35-44 and 45-59 years old. Among women, COVID-19 was most prevalent in reproductive workforce age of 25-34 years with a 9.1% total case proportion. Gender-based strategies are therefore strongly recommended.



In most Africa countries, gender disaggregated data are incomplete. Based on the gender analysis data discussed in this publication and the evident predominance of COVID-19 among the male gender in these two countries, caution must be exercised against early assumptions. Therefore, it will be beneficial if member states incorporate a gender analysis into preparedness, response and surveillance efforts in order to improve the effectiveness of COVID-related interventions and promote gender equity. Additionally, a standardization of reporting formats of gender and age disaggregated data on COVID vulnerability and mortality needs to be adopted in order to achieve a uniform analysis of the gendered impact of the COVID- 19 pandemic at continent level.

Vaccination is a key preventive measure that brings hope in accelerating efforts to controlling the pandemic and possibility of achieving country-wide immunity. With the continued high pace of transmission of the current novel COVID-19 virus, countries and continents have adopted globally recommended policies and safety guidelines such as use of personal protective equipment, regular hand washing, social distancing and isolations while awaiting a safe and effective vaccine.

Typically, vaccine trials require several rounds of testing in animals and man usually in four phases lasting months to years. Despite the race by researchers to develop a COVID-19 vaccine, as at September 2020, more than 169 COVID-19 vaccines are under trial[1] and none have been formerly approved for public use. According to the World Health Organization (WHO), of these 169 vaccine trials; 60% are at pre-clinical stage, 16% in phase 1, 10% in phase 2 and 4% in phase 3, while none in phase 4 (i.e. approved for general use)[2]. In the Africa region, only one (1) African country – South Africa, is currently participating in the trials. This serves as a starting point in identifying the vaccine challenge in Africa- limited capacity, resource and political will to support research and development for COVID-19 containment in Africa.

In an attempt to stimulate the Africa research community to join the race of developing a safe COVID-19 vaccine, a newly proposed expedited protocol review process for COVID-19 clinical research in Africa was developed and presented by the African Vaccines Regulatory Forum (AVAREF) – established since 2006 to provide regulatory and ethical oversight on interventional clinical trials conducted within the Africa region. Notwithstanding, Member states of the Africa Union have failed to tap into this opportunity. What then should Africa do while other researchers in other countries and continents develop a safe and effective vaccine? Prepare for consumption! But then, how ready are we?

Under the assumption that a safe and effective COVID-19 vaccine is developed at end of the year 2020 or middle of 2021; there are key elements if left unaddressed, that will be mirrored as challenges. These elements follow the same principles as the cornerstones of health care delivery; - (i) Cost (ii), Access and (iii) Quality.

Cost: Will the vaccine be provided free to the general public? To promote community adoption and utilization of the new vaccine, Africa must ensure that the vaccine is provided free of charge. Additionally, countries will need to deploy context-specific community engagement strategies to curb against vaccine hesitancy and promote acceptability. This can be achieved through strategies such as advocacy, engagement of community leaders, community sensitization, mobilization and outreaches. These proposed community engagement approaches can only thrive successfully if the vaccine is free. Mobilizing resources for a vaccine procurement and negotiating vaccine access agreements is a great start!

Access: Are Member states equipped with a robust supply chain system and strategy? Who qualifies to receive the vaccine? Who will administer the vaccine? Will its administration be incorporated into national Immunization programs? Will the procurement and distribution be sustained? To institutionalize country readiness and achieve equitable access, Member states must address these questions, enhance supply chain systems, develop eligibility criteria for COVID-19 vaccination, develop a sustainability plan for procurement and distribution, amidst other efforts.

Quality: Quality assurance spans through production, procurement, storage, entire supply chain distribution and management. As Africa await the development of a quality vaccine, countries must ensure efficient storage systems and resources for capacity enhancement for COVID vaccine management are built to prevent wastages and ensure the quality of procured vaccines are maintained.

[1] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines

[2] https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines

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Border Restrictions; Our Pandemic Future

According to the Centre for Disease Control and Prevention (CDC), travel increases chances of spreading COVID-19[3]. In the wake of the pandemic, Africa Member states scrambled to shut their borders to international and commercial travels and declared lockdowns for country inhabitants. States and local governments within countries also instituted travel restrictions in firm support of country level efforts and policies targeted at mitigating the spread of COVID-19. As the epidemic curve of COVID-19 cases began to plateau at the end of July 2020 for most Member states, Africa countries began to open its borders, but with caried protocols and travel requirements.

Across the 55 Africa Union Member states, more than 25 countries have lifted their travel restrictions allowing international and local flights of disparate levels, lifted curfews and slowly recommencing tourism and commerce[4]. These countries include Seychelles, Tanzania, Rwanda, Tunisia, Egypt, Liberia, Senegal, Mali, Djibouti, Sierra Leone, Chad, Kenya, Togo, Democratic Republic of Congo, Burkina Faso, Sao Tome and Principe, Ethiopia, Zambia, Ghana, Namibia, Nigeria, Mauritania, Mauritius, Uganda, Zimbabwe and South Africa.

COVID-19 has significantly impacted not only on nation's economies, but also our social interaction and physical connections. Core travel requirements demanded by countries that have opened their borders include (i) A negative COVID-19 PCR test result with varying duration of validity across countries prior to arrival (ii) mandatory wearing of masks (iii) Obtaining body temperature readings (iv) Self-isolation or quarantine.

Most Africa nations require a negative PCR of no more than 72hrs, while other nations consider negative results still valid for up to 7 days prior to in-country arrival. Some member states require a mandatory withholding of travel passports until COVID-19 PCR test results are confirmed negative and self-isolation has been implemented by traveler.

Overall, this is Africa's new normal- new norms to our future in the era of a pandemic!

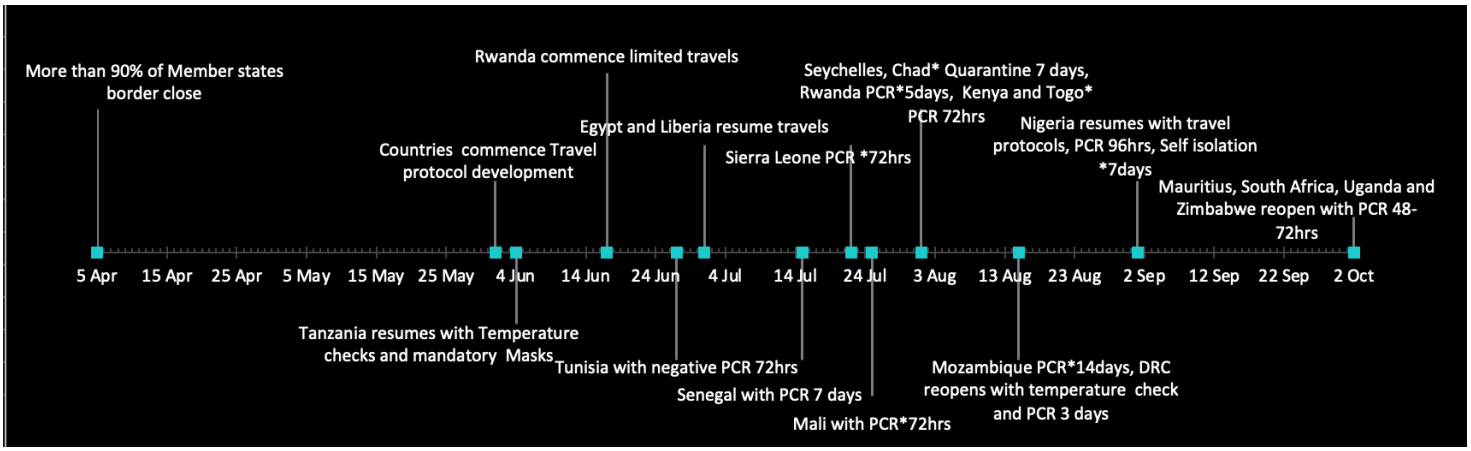

Figure 1: Timelines of Border restriction and Re-openings among Africa Union Member States

[3] https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html
[4] https://www.traveloffpath.com/africa-reopening-for-tourism/