AFRICA COVID-19 BRIEF
AUGUST 2021

African Alliance

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INTRODUCTION

On a monthly basis, the African Alliance will be providing a monthly brief on the COVID-19 situation on the African continent. Compiling information from a variety of sources, including the African Union, World Health Organization, and collaborating organizations on the continent, the African Alliance will provide a snapshot of the burden of disease across Africa, as well as the state of vaccine rollout. This report will strive to document issues related to and as a consequence of vaccine access, hesitancy and confidence in the second year of COVID-19 in Africa, ensuring representativity of media and civil society voices.

How to use this report:

The first two sections of the report (**CASES AND DEATHS** and **VACCINE ROLLOUT**) aim to give a very brief overview of the situation across the continent. This sections should be viewed as a snapshot of essential data.

The third section of the report (**COMMENTARY FROM AROUND THE CONTINENT**) aims to showcase a diverse set of voices from around the continent, highlighting issues of interest related to COVID-19 burden, vaccine equity, and related advocacy in all African regions. The African Alliance will aim to showcase original pieces written for this report. However, when original pieces cannot be sourced by report release date, valuable commentary featuring African voices will be carefully selected from a variety of African and international outlets.

The fourth section of the report (**AFRICA MEDIA ROUNDUP**) will showcase few interesting COVID-19 related news pieces from a variety of African news sources. This is in recognition of the fact that much of the news coverage about Africa comes from outlets in the Global North. In this report, we aim to share work developed by outlets in Africa, in order to get a flavor of what local reporters are gathering and writing about the pandemic and its impacts. A link to the stories will be provided, along with blurbs summarizing why the stories are worth reading.

Finally, the section titled **SO WHAT?** lists a few suggested advocacy directions generated from the content of the report.

CASES AND DEATHS

In the month of August, the number of daily new confirmed COVID-19 cases remained consistently high before reaching its peak on August 10 (39,006 new cases). The continent experienced the highest increase in the number of new cases during its steepest incline between August 22 (34,340 new cases) and August 23 (37,145 new cases) (Figure 1). The number of daily new confirmed deaths also remained relatively high (peak August 4: 984 confirmed deaths), before beginning to drop on August 18 (Figure 2).

Figure 1: Showing Daily New Confirmed COVID-19 Cases (source: Our World in Data)

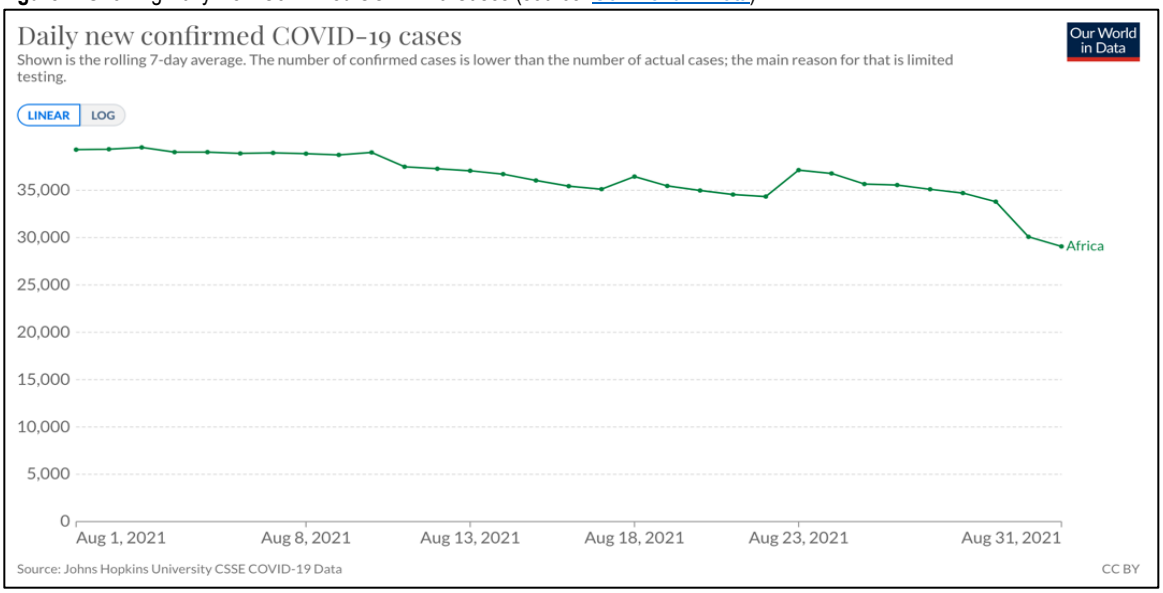
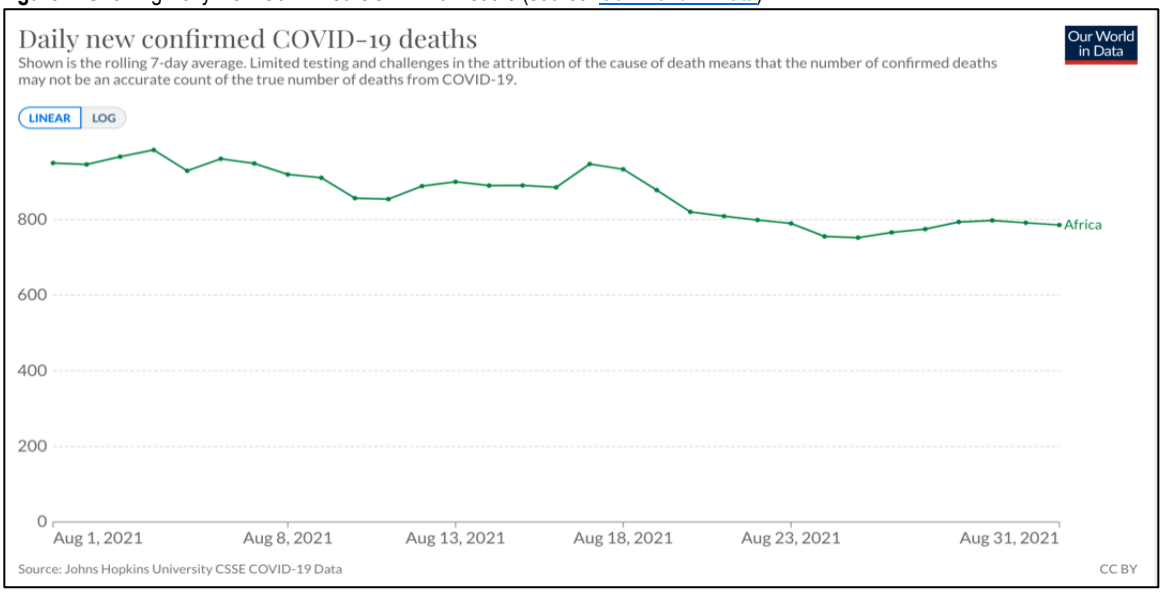


Figure 2: Showing Daily New Confirmed COVID-19 Deaths (source: Our World in Data)



Following trends from the month of July, cases (Figure 3) and deaths (Figure 4) were primarily concentrated in the southern region of the continent. South Africa's numbers remained higher than those of other African countries, reaching a peak of 12,105 confirmed cases on August 18 and 398 confirmed deaths on August 17.

Figure 3: Showing Map of Daily New Confirmed COVID-19 Cases, August 31, 2021 (Source: Our World in Data)

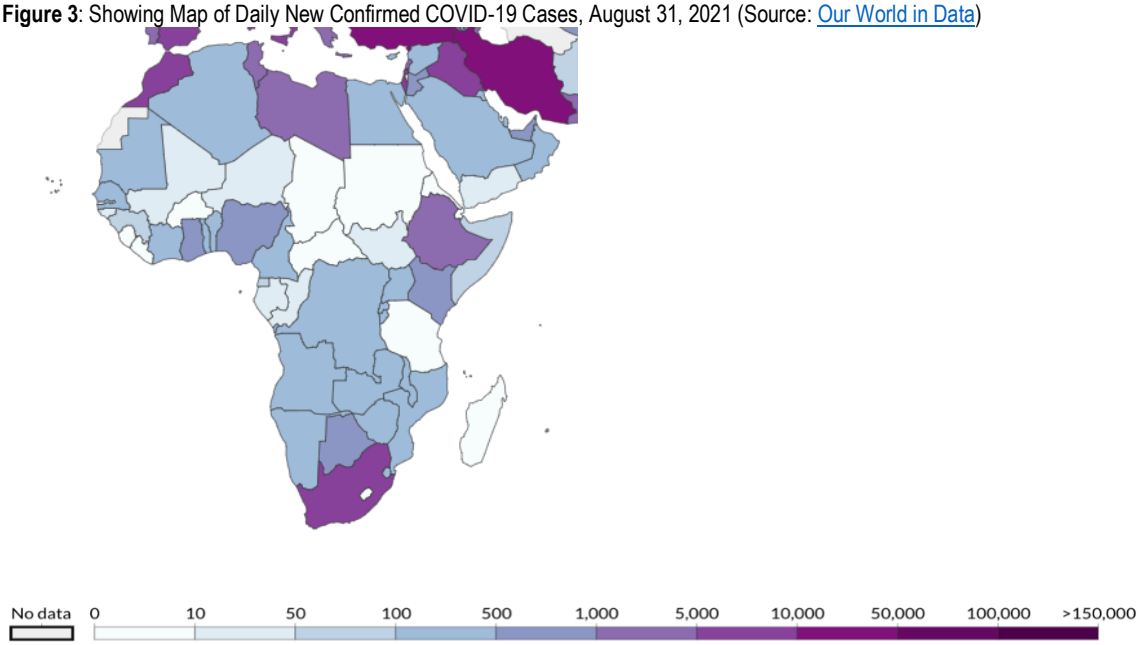
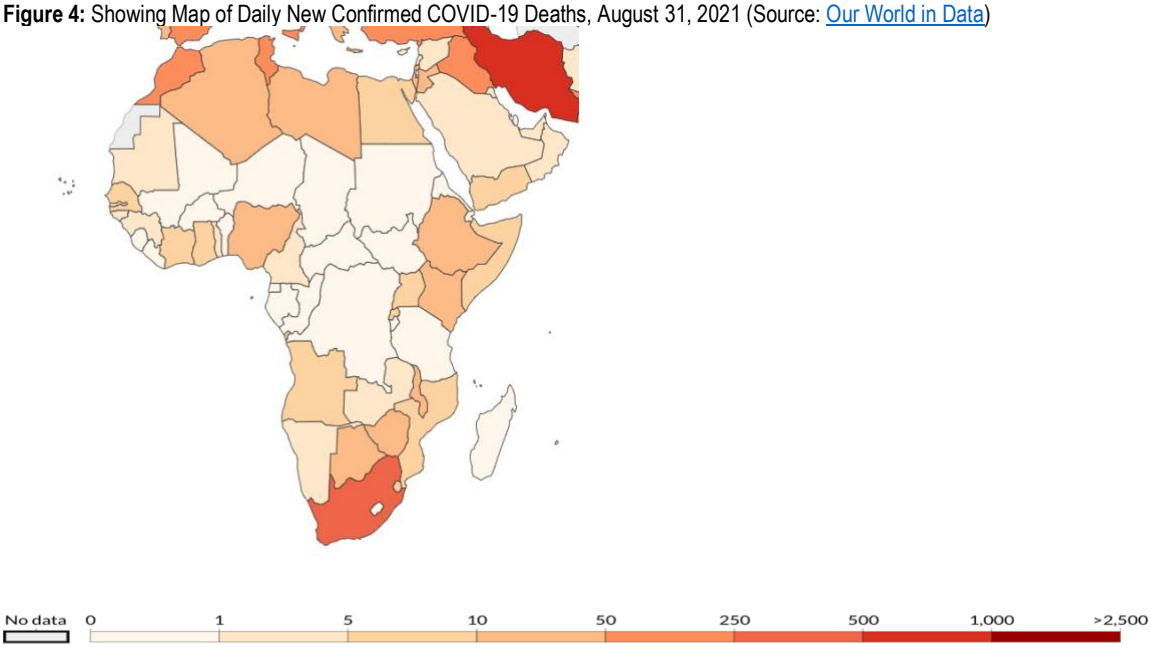
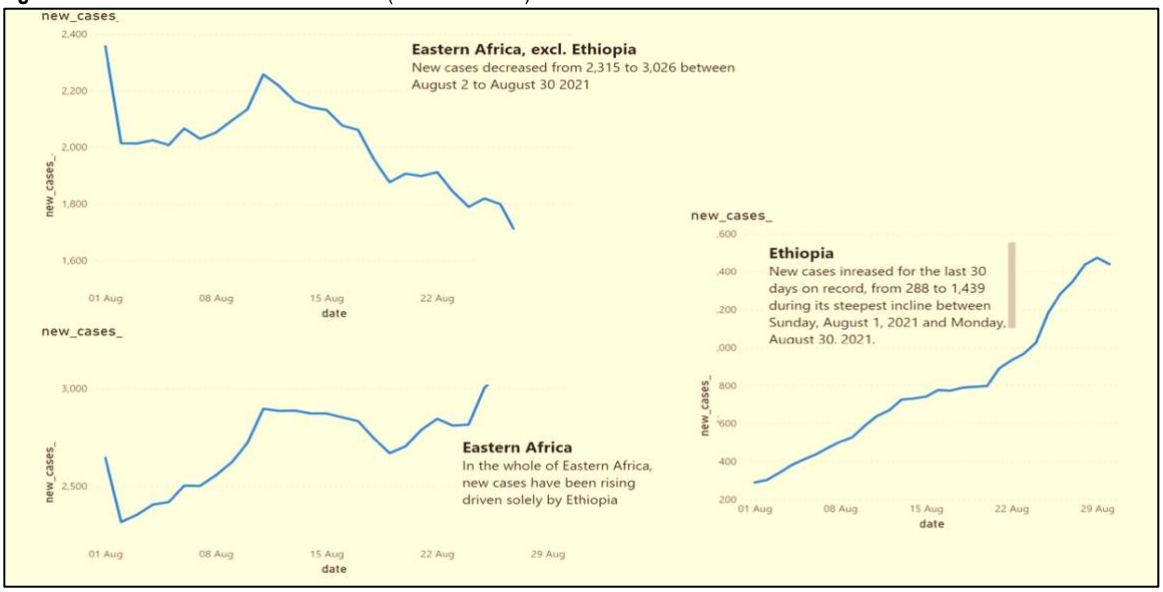


Figure 4: Showing Map of Daily New Confirmed COVID-19 Deaths, August 31, 2021 (Source: Our World in Data)



One additional important trend is the worrying situation in Ethiopia. The incidence in Ethiopia has been driving the rise in cases in the entire East African region. (Figure 5) In this country – the second most populous in Africa – new cases jumped by 400% during the month of August.

Figure 5: A Closer Look at East Africa Data (Source: Oxfam)

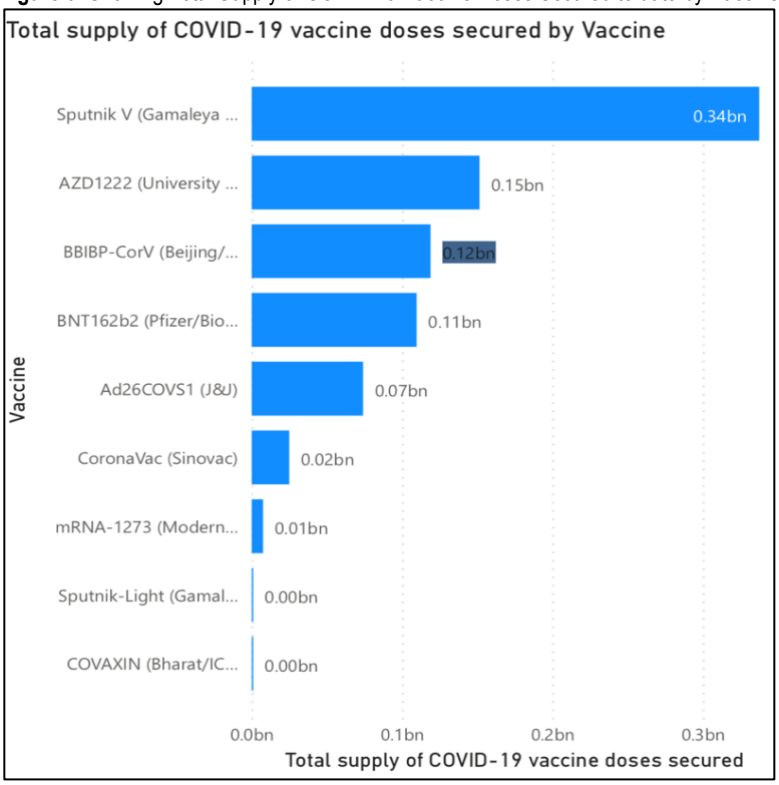


VACCINE ROLLOUT

Across the continent, 825 million COVID-19 vaccine doses were secured by the end of the month. Of those, 143 million had been delivered by the end of August. [1]

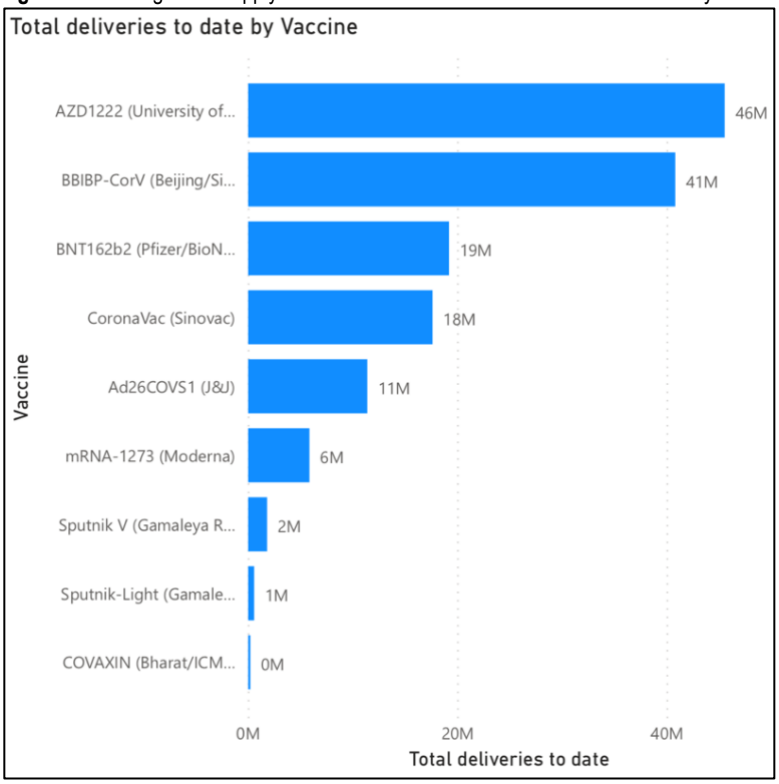
Sputnik V accounted for the highest secured supply of COVID-19 doses (340 million or 0.34 billion doses), followed by Johnson & Johnson (150 million or 0.15 billion doses), and Sinopharm (120 million or 0.12 billion doses), and Pfizer (110 million or 0.11 billion doses) (Figure 6). AstraZeneca was the most widely used vaccine in the continent, accounting for 46 million of the total delivered doses, followed by Sinopharm with 41 million deliveries to date (Figure 7).

Figure 6: Showing Total Supply of COVID-19 Vaccine Doses Secured to date by Vaccine Type (Source: Oxfam)



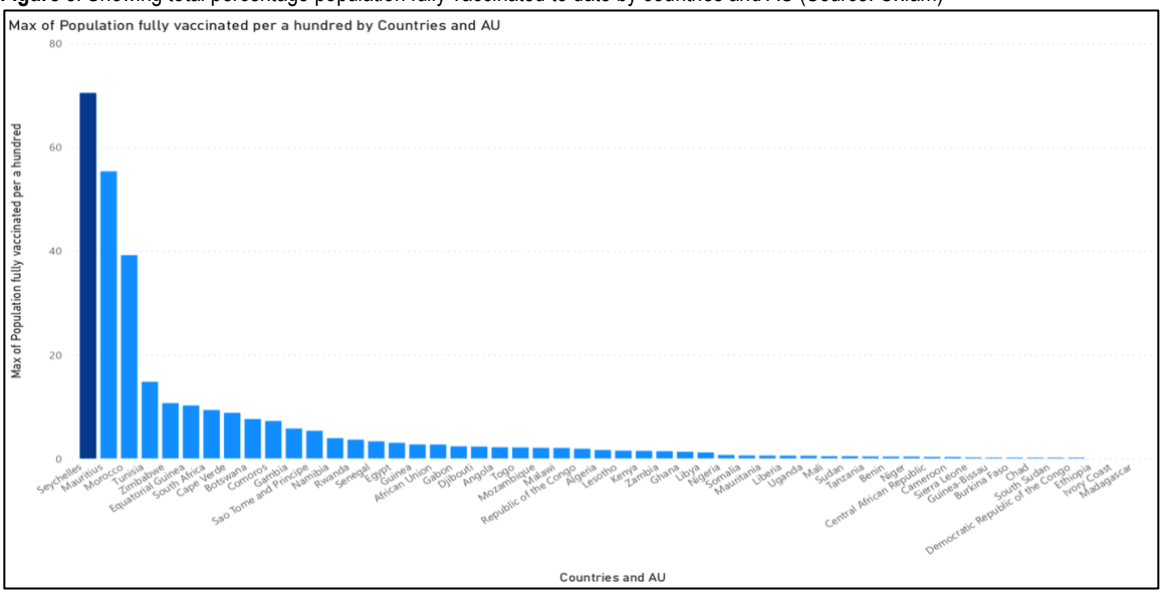
[1] Note: for the purposes of these reports, Oxfam and African Alliance differentiate between vaccines *secured* (promised), *delivered* (a binding deal made following a promise) and *administered* (injected into an arm).

Figure 7: Showing Total Supply of COVID-19 Vaccine Doses Delivered to date by Vaccine Type (Source: Oxfam)



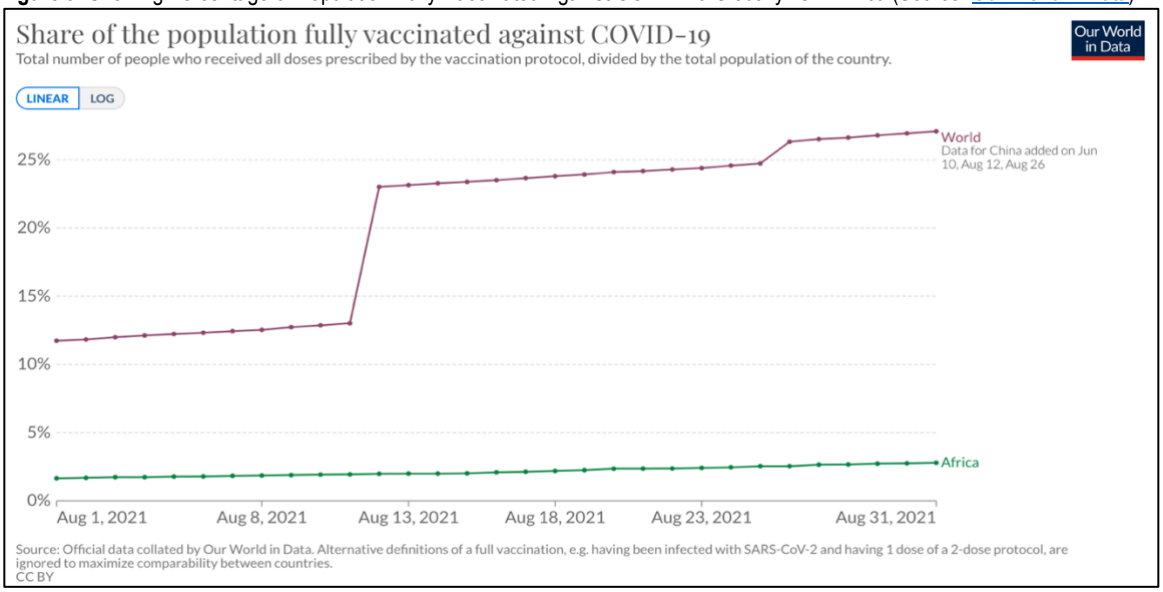
By the end of August, Seychelles had vaccinated the greatest percentage of its population, followed by Mauritius, and Morocco (Figure 8). One hundred million doses have been administered in Africa, a continent with a population of approximately 1.3 billion people.

Figure 8: Showing total percentage population fully vaccinated to date by countries and AU (Source: Oxfam)



Striking inequity persists between the percentage of people fully vaccinated in Africa vs those fully vaccinated across the world. This has actually worsened since last month. In Africa, we are still at a dismal 2.79% of fully vaccinated individuals (compared to 27% globally), up only a fraction since July 31 (Figure 9).

Figure 9: Showing Percentage of Population Fully Vaccinated Against COVID-19 Globally vs in Africa (Source: Our World in Data)



Profiteering from vaccine inequity: a crime against humanity?
By Fatima Hassan et al.
August 16, 2021

Companies and rich nations are creating a deadly covid-19 vaccine "protection racket"
Early in the pandemic, Pfizer announced an intention to profit from its covid-19 vaccine. In the first three months of 2021, Pfizer's vaccine brought in $3.5bn (£2.5bn; €3bn) in revenue and hundreds of millions in profit. Other companies are also making exceptional profits from covid-19. Moderna, which received public funding to develop its covid-19 vaccine, will earn several billion dollars from vaccine sales. Even Astra Zeneca, with its acclaimed "non-profit" model, will receive billions in revenue and is free to raise the price once it considers the pandemic to be over.

But the rich world is refusing to share vaccines with poorer countries speedily or equitably. Whereas 60% of the population in the UK is fully vaccinated, in Uganda it is only 1%. The 50 least wealthy nations, home to 20% of the world's population, have received just 2% of all vaccine doses. The rich world should be ashamed.

The World Health Organization wants rich nations to halt booster vaccination and instead send doses to less wealthy nations—yet Pfizer is expecting rich nations to ignore WHO and recommend boosters, helping to increase its expected revenues to $33.5bn.

Pandemic profiteering is, in our view, a human rights violation that demands investigation and scrutiny. The Universal Declaration of Human Rights states that everyone has the right "to share in scientific advancement and its benefits." Such advancement led to accelerated development of effective Covid-19 vaccines, with public funding, that lower the chances of severe illness and death.

Vaccine preventable deaths and illness are occurring across Africa, Asia, and Latin America at an unprecedented speed and scale. These continents are being outmanoeuvred by rich nations flexing their market power. Let us be clear what is causing these deaths: a free market, profit driven enterprise based on patent and intellectual property protection, combined with a lack of political will. Contrary to claims, it is possible to make enough vaccines for the world.

Vaccine apartheid
Vaccine manufacturers and their chief executives, accountable only to their boards, have worked with a group of powerful leaders to amass doses. By September 2020, around 30 rich nations—those able to pay high vaccine prices—had cleared the world's shelves of doses through advanced purchase orders, leading to vaccine apartheid. Canada purchased enough doses to vaccinate its citizens five times over. The UK procured enough doses for four times its population. By the end of 2021, rich nations will be sitting on one billion unused doses, even though some poorer countries have not yet received the vaccines that they have paid for. WHO's director general, Tedros Adhanom Ghebreyesus, called global vaccine inequity "grotesque," a recipe for seeding viral variants capable of escaping vaccines, and a "moral outrage."

But perhaps calling it a moral outrage isn't enough? Where is the redress for decisions that deny intellectual property waivers and withhold manufacturing knowledge—decisions that lead to hundreds of thousands of premature deaths in disadvantaged countries?

Some vaccine-rich countries are now destroying excess, unused doses. And some have imposed export bans and restrictions to protect their stockpiles. Ironically, vaccine companies prevent poorer countries from insisting on similar measures.

To try to prevent such hoarding, a global vaccine sharing mechanism called Covax was launched last year. Designed as a "global powerhouse," Covax aimed to buy enough doses to vaccinate at least 20% of people in 92 poorer

countries by the end of 2021. It is way off target. Rich nations pushed Covax to the back of the queue of buyers, and it has struggled with procurement, delivering just 163 million doses, far short of the billions of doses needed. Disappointingly, the G7 agreed to donate less than 8% of the required doses to Covax.

The governments of India and South Africa are leading a proposal to temporarily waive intellectual property protection on covid-19 technologies, backed by over 100 countries. But vaccine manufacturers and many rich countries are working tirelessly to block waiver discussions at the World Trade Organization, which itself is acting sluggishly. Oxfam has accused the G20 rich nations of putting relations with pharmaceutical companies ahead of ending the pandemic.

Knowledge must be shared

In May 2020, WHO launched the Covid-19 Technology Access Pool (C-TAP), calling on vaccine developers to share vaccine know-how through pooling and voluntary licensing agreements in a pandemic. In June 2021, WHO announced that it was working with a consortium of South African vaccine companies, universities, and the Africa Centres for Disease Control and Prevention to establish its first Covid mRNA vaccine hub. But no major company with a WHO approved vaccine has shared technology with C-TAP or the WHO hub. Most governments are reluctant to make it compulsory to share such knowledge. There was some hope that Oxford University's vaccine, developed through public funding, would be made open source, but the rights are assigned exclusively to AstraZeneca, which has not been fully transparent about its pricing and other sub-licensing terms.

Amid the worst pandemic in 100 years, instead of a freely available public good, vaccines remain a commodity owned by companies and sold to the rich. Instead of hoarding one billion "excess" doses this year, rich nations could give them to Covax. While such "charitable donations" are a first step, they are not enough. Donations are a vestige of colonial injustice and reparations are long overdue. The current "trickle down" colonial charity model has failed.

The only sustainable way forward is to globalise manufacturing so that disadvantaged countries no longer rely entirely on charity. This was achieved with the AIDS crisis, but only after many years and many more deaths. Poorer countries require relaxation of intellectual property rights, technology transfer, and support to rapidly establish regional vaccine manufacturing hubs. Africa, Asia, and Latin America are perfectly capable of producing vaccines, and to claim otherwise is a misleading argument.

Politicians may still damage a country's pandemic response, even when vaccine manufacturing capability exists, as seen in India. But the overwhelming moral imperative to share intellectual property, technical expertise, and manufacturing capability still stands.

Surprisingly, some richer nations—for example, in east Asia—are also short of vaccine supplies because they prioritised strict containment strategies to save lives over aggressive vaccine procurement. Their pandemic strategies are now hanging by a thread, at the whim of big pharma and popularity politics in the West.

Ultimately, those who refuse to waive patents and share knowledge will only damage their own long term interests because corporate and political entities in China, India, and Russia are already beginning to fill the void.

Silence is complicity

Covid-19 global vaccine allocation is based on power, first mover advantage, and the ability to pay. This moral scandal, enabled by corporate and political permission of mass death, is tantamount to a crime against humanity. Yet we too are complicit by our silence. Why are workers and shareholders at vaccine companies not speaking out? Where are the academics clamouring to make the "fruits of the scientific enterprise" available to all? Where are the lawyers demanding global justice and corporate accountability? Which leaders of rich nations are pressuring vaccine companies to make their people safe by making the world safe? Where is the grassroots mobilisation of scientists and health workers to fight for fair access to vaccines?

Global vaccine inequity is toppling all our successes in rapid vaccine development and is needlessly prolonging the pandemic. Ongoing inequity is a direct consequence of commercial greed and political self-interest. Under the cover

of serving humanity, and with a blind eye turned towards the innumerable deaths in disadvantaged nations, corporations aided by their political allies are once more doing what they do best: making a killing.

Fatima Hassan is a human rights lawyer and social justice activist and the founder of the Health Justice Initiative. She is the former Executive Director of the Open Society Foundation for South Africa. She has dedicated her professional life to defending and promoting human rights in South Africa, especially in the field of HIV/AIDS where she worked for the AIDS Law Project and also acted for the Treatment Action Campaign in many of its legal cases. This piece was published in BMJ.

Au-delà du Covid, l'équité vaccinale doit devenir la norme
August 23, 2021
By Dr Catherine Kyobutungi

La pandémie actuelle a révélé la dépendance de l'Afrique envers le reste du monde en matière de santé. Il est temps d'y remédier.

L'importance que revêtent, dans nos sociétés, les principes d'équité et d'inclusion fait l'objet d'une prise de conscience mondiale.

Aujourd'hui, chacun s'accorde à dire qu'une répartition égale des ressources est essentielle pour faire face à la plupart des défis sanitaires. Les problèmes de santé publique les plus graves peuvent presque tous être résolus, mais les solutions ne sont pas facilement accessibles à ceux qui en ont le plus besoin. Là réside l'iniquité.

Bien que ces disparités et inégalités ne soient pas nouvelles, la discussion prend de l'ampleur. Alors que la planète est engagée dans une course contre la montre pour mettre fin à la pandémie de Covid-19, un facteur y fait obstacle : l'iniquité vaccinale.

Vagues dévastatrices
En juillet 2021, 85 % des doses de vaccin administrées dans le monde l'avaient été dans des pays à revenus élevés et intermédiaires supérieurs, et moins de 1 % dans des pays à faibles revenus. Or les pays à revenus intermédiaires et faibles représentent plus des trois quarts de la population mondiale.

Le continent africain est probablement celui qui souffre le plus de cette inégalité. Alors qu'il abrite 17 % de la population mondiale, seules 4 doses pour 100 personnes ont été administrées à ce jour, contre 76 en Amérique du Nord, 74 en Europe, 48 en Amérique du Sud et 46 en Asie.
En juin 2021, moins de 1 % des Africains avaient reçu deux doses. Moins de 2 % des 2,7 milliards de doses de vaccin contre le Covid-19 administrées dans le monde l'avaient été en Afrique.

À l'évidence, l'inégalité de cette distribution freine la réponse mondiale à la pandémie. Alors que la vie est sur le point de revenir à la normale dans les pays à forts taux de vaccination, plusieurs États à faibles taux de vaccination sont aux prises avec des vagues dévastatrices : nouvelles infections, hausse du nombre de personnes hospitalisées et des décès.

Propagation des variants
Parallèlement, la propagation de nouveaux variants, principalement parmi les non vaccinés dans les pays où la population a été largement vaccinée, fait craindre une résurgence du virus dans ces pays.

Selon l'OMS, l'Afrique risque fort de se trouver face à une troisième vague, en raison du trop lent déploiement du vaccin et de la propagation des variants. Si tel était le cas, les systèmes de santé du continent, déjà sous pression, seraient mis à rude épreuve. Cela entraînerait davantage de décès et l'érosion des acquis obtenus dans la lutte contre le VIH/sida, la tuberculose, le paludisme, la santé maternelle et infantile, etc.

La question de l'iniquité vaccinale doit donc être abordée au plus vite. Personne n'est en sécurité tant que tout le monde n'est pas en sécurité ; il est temps d'agir.

La communauté mondiale doit se mobiliser rapidement, faute de quoi nous risquons de prolonger la pandémie. Les pays, quels que soient leurs pouvoirs d'achat respectifs, doivent travailler de concert pour éliminer les obstacles à l'accès aux vaccins, et entreprendre des actions visant à renforcer la chaîne approvisionnement-production-distribution.

Indépendance

Au-delà du risque de prolongation de la pandémie qu'elle fait courir, l'iniquité vaccinale a amplifié les inégalités sanitaires et financières à l'échelle planétaire. Selon la Banque mondiale, une distribution équitable des vaccins est essentielle à la reprise économique mondiale.

Les dirigeants, les gouvernements, le secteur privé et la communauté scientifique doivent redoubler d'efforts pour renforcer la recherche vaccinale contre le Covid-19. Ils doivent aussi lever les obstacles à la distribution mondiale de vaccins et les facteurs limitant leur accès.

L'Afrique ne produit que 1% des vaccins utilisés sur le continent pour la prévention des maladies infantiles.

Cela illustre la nécessité d'augmenter les capacités de fabrication de médicaments ou de vaccins, et de renforcer les organismes de réglementation du continent.

À plus long terme, les pays à revenus faibles et intermédiaires doivent lutter pour acquérir une indépendance vaccinale en investissant dans leurs propres capacités de fabrication. Le CDC Afrique, par exemple, met en œuvre un plan visant à ce que cette production ne couvre plus 1% mais 60% des besoins du continent d'ici à 2040.

En outre, les gouvernements africains doivent continuer à investir dans la recherche scientifique locale, sur le Covid-19 comme sur les maladies infectieuses en général, qui menacent le développement. Des recherches prometteuses ont vu le jour en Ouganda et au Nigeria, où des candidats vaccins contre le Covid-19 sont en cours d'élaboration. Ces exemples pourraient inspirer de nombreux autres pays. L'Afrique sera plus proche de l'équité vaccinale à l'avenir si elle dispose de ses propres candidats vaccins, qu'ils soient fabriqués sur le continent ou ailleurs.

Barrières commerciales

Atteindre cette équité relève également d'un effort mondial. Les pays développés doivent augmenter leur allocation de vaccins, accroître leur aide financière au programme AMC de la Covax et à d'autres initiatives visant à fournir des vaccins aux pays à revenus faibles et intermédiaires. Les pays du G7 ont ainsi promis 870 millions de doses supplémentaires à la Covax et aux pays à faibles revenus. Il est indispensable que ce mouvement se poursuive.

Les fabricants doivent faire en sorte d'augmenter leur production jusqu'à qu'il y ait un nombre de doses suffisant pour vacciner la majeure partie de la population mondiale.

Il est tout aussi important que la communauté scientifique mondiale continue de développer de nouveaux vaccins, sûrs et efficaces, contre le Covid-19 car disposer de davantage d'options augmentera les disponibilités globales de vaccins.

Pour les pays à revenus élevés, intensifier le partage des doses excédentaires est un impératif. Il incombe aux gouvernements du monde entier de réduire les obstacles à la chaîne d'approvisionnement, à la fabrication et à la distribution de vaccins : barrières commerciales, contrôles à l'exportation et goulets d'étranglement réglementaires.

L'Afrique et les autres pays à revenus intermédiaires de la tranche inférieure doivent éliminer les obstacles à l'équité vaccinale dans leur propre pays (mauvaise distribution, désinformation, etc.) et veiller à ce que les vaccins soient largement distribués, en particulier aux personnes à risque. Il est de la responsabilité des gouvernements d'investir davantage dans des campagnes de sensibilisation portant sur l'innocuité et l'efficacité des vaccins.

Le monde peut devenir meilleur et plus fort. L'équité vaccinale est un moyen d'y parvenir.

Dr. Catherine Kyobutungi is the Executive Director of the African Population and Health Research Center (APHRC). She was formerly the Center's Director of Research and has served APHRC in several leadership roles over the past

15 years, having joined as a post-doctoral fellow in 2006. She holds a Ph.D. in Epidemiology and a Master of Science in Community Health and Health Management from the University of Heidelberg. She is the co-director of the Consortium for Advanced Research Training in Africa (CARTA), a program that seeks to build and strengthen the capacity of African research leaders and has trained more than 230 PhD fellows in eight African universities. This piece (titled ***Beyond COVID, vaccine equity must become the norm)*** *was published in jeunafrique.*

Europe raids Africa' s few Covid doses for itself
The East African (Kenya)
August 21, 2021
In August, it emerged that Europe was importing Johnson & Johnson vaccines from South Africa's Aspen Pharmacare, which was only recently licensed to begin production especially for African countries which had been locked out of the international supply chain. This article summarizes the uproar that accompanied those revelations, given the very high rate of vaccination access in Europe compared to the still very low vaccine access across the African continent. The piece highlights demands for disclosure of the South African government's contract with Johnson & Johnson and other vaccine manufacturers as well as statements from former UK Prime Minister Gordon Brown (who called the actions "neo-colonial") and WHO Africa Regional Director Dr Matshidiso Moeti (who continues to remind people that vaccine nationalism risks extending the pandemic by creating conditions where the virus will very likely mutate further ultimately delaying the global recovery from the pandemic as newer more lethal variants emerge).

How hesitant are South Africans about getting vaccinated?
GroundUp (South Africa)
August 20, 2021
Vaccinations are now open to all adult South Africans. In recent weeks, there has been growing concern that demand for vaccines among people over 35 is waning. Large surveys on people's views on getting vaccinated have produced contrasting results. The headline findings from the University of Johannesburg's (UJ) Centre for Social Change, in collaboration with the Human Sciences Research Council (HSRC), were that the overall rate of vaccine acceptance was 72%, up from 67% recorded in the previous round, which was conducted in late December 2020. Similarly, the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS CRAM) found that the share of people who would accept a vaccine rose from 71% to 76%. But one major poll, the Afrobarometer survey, run by the Institute of Justice and Reconciliation, found that vaccine acceptance was far lower than the figures reported by NIDS CRAM or UJ/HSRC. According to Afrobarometer's results, a massive 42% of respondents were very unlikely to get the vaccine. Based on commentary from the researchers themselves, as well as other experts, this article breaks down possible reasons for the discrepancies between the results: question formatting (including, importantly, an Afrobarometer question that tied trust in vaccines to trust in the government), the geographical scope of the studies, and the period of time during which the surveys were conducted. The articles notes that vaccine confidence is critical and the volatility of the results also hints at the fact that popular belief in vaccines is fragile and easily swayed, highlighting the need for it to be effectively addressed in order to turn COVID into a "low mortality disease."

'Nigeria, two others experiencing surge in COVID-19 deaths amid cholera, other outbreaks'
Punch (Nigeria)
August 20, 2021
According to WHO Africa Regional Office, Nigeria, Cote d'Ivoire, and Guinea are experiencing a surge in COVID-19 deaths as West African health systems struggle to face the third wave of the COVID-19 pandemic while also in the midst of Cholera, Ebola, and Marburg Virus outbreaks. Although the COVID-19 case fatality ratio (proportion of people diagnosed who have died) is lower than the continental average, it is higher during this wave, than it was in the previous two waves of the pandemic, with infections rising for eight weeks straight, through mid-August. This article also quotes Dr. Matshidiso Moeti (the WHO Africa Director) pointing out that, in the face of a confluence challenges, COVID-19 vaccination rollout in West Africa has been slower than that in East and Southern Africa. The region is one of concern, deserving particular attention.

Covid-19 : en Algérie, le système de santé au bord de l'explosion (COVID-19: In Algeria, the health system is on the verge of explosion)
jeuneafrique (Pan-African)
August 1, 2021
Since the Delta variant hit the country a few months ago (causing 90% of recent infections), COVID-19 cases have spiked worryingly in Algeria. Practicing medicine in "war like conditions" as oxygen supplies run out and COVID-19 deaths rise, health care workers are calling for a "health state of emergency". The article notes that only 10% of the population had been vaccinated as of mid-July, partially due to a dependence on COVAX, which did not deliver as expected, and caused a slow start to the vaccination campaign for the first half of 2021. The piece quotes the President of the National Agency for Health Security, who predicts that the country will fail to meet its upcoming vaccination goals, simply because there are still not enough doses available.

SO WHAT?

The current conflict in Ethiopia appears to be fueling a terrifying rise in COVID-19 cases in the country. It is no coincidence that Ethiopia is also lagging behind vaccine rollout, currently third from last in percentage of individuals vaccinated (see Figure 8). This highlights the need to pay special attention to countries experiencing political and other situations that limit people's ability to protect themselves from exposure and thwart any attempt at a COVID-19 response by local and national government. Unfortunately, Ethiopia is but one of the African countries experiencing conflict at the moment. African civil society should encourage continental leadership to pay special attention to these countries and ensure that bodes such as the African Union and African Centers for Disease Control and Prevention are held to account for their commitments and deliverables.

The BMJ piece (**Profiteering from vaccine inequity: a crime against humanity?)** by Fatima Hassan and colleagues highlights the rampant pandemic profiteering by pharmaceutical companies – entities that shouldered hardly any of the risk of COVID-19 vaccine development (due to government funding) and are now reaping all the rewards. The authors ask: *Why are workers and shareholders at vaccine companies not speaking out? Where are the academics clamouring to make the "fruits of the scientific enterprise" available to all? Where are the lawyers demanding global justice and corporate accountability? Which leaders of rich nations are pressuring vaccine companies to make their people safe by making the world safe? Where is the grassroots mobilisation of scientists and health workers to fight for fair access to vaccines?* It is our role as African civil society to continue using a combination of encouragement and shame to push people in the right direction on these fronts.

In her piece titled **Beyond Covid, vaccine equity must become the norm** Dr. Kyobutungi points out that the pandemic has renewed a global awareness of the importance of equity and inclusion in our societies. In addition to highlighting some of the points that advocates have been focused on for the last few months (loosening of trade barriers, dose redistribution, scaling up of COVID-19 vaccine manufacturing capability in low-income countries), she also points out that the vaccine independence from Africa must go beyond COVID. She states, "*In the longer term, low- and middle-income countries must strive for vaccine independence by investing in their own manufacturing capacity. CDC Africa, for example, is implementing a plan to shift production from 1% to 60% of the continent's needs by 2040*," and finishes by stating "*The world can become a better and stronger place*." Dr. Kyobutungi's call is a reminder to advocates to work on immediate needs, while also keeping a focus on the longer-term goals, which include improving the continent's ability to better deal with future pandemics as well as ongoing chronic health issues.

The review of COVID-19 news from around the continent reminds us of the need to continue forging relationships with civil society comrades from all regions. And lessons learned from one region might be adaptable and applicable for another. In South Africa, for example, civil society supported the disclosure of information related to the Johnson & Johnson vaccine export story. That is a case of successful advocacy, which was of great interest to comrades from across the continent. Health Justice initiative was invited to share their work and insights on this issue at the August 31 People's Vaccine Alliance Africa meeting. African Alliance will continue facilitating dialogue on this and other important advocacy points in as many venues (online and offline) as possible in the coming months, encouraging the sharing of effective strategies and lessons learned.