AFRICA COVID-19 BRIEF
JULY 2021

African Alliance

INTRODUCTION

On a monthly basis, for the period June – December 2021, 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 also 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.

CASES AND DEATHS

In the month of July, the number of confirmed COVID-19 cases rose steadily (peak: July 15 with 41,868 new confirmed cases) before seeing a slight, temporary drop in the middle of the month and picking back up toward the end of the month (Figure 1). The number of confirmed COVID-19 deaths rose steadily before reaching its highest point for the month of July – 974 new confirmed COVID-19 deaths—on July 30, 2021 (Figure 2).

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

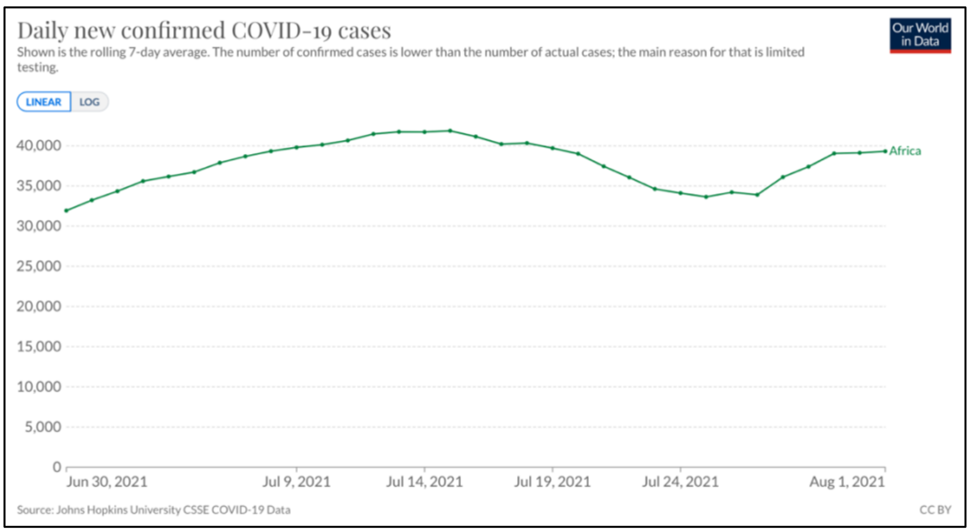
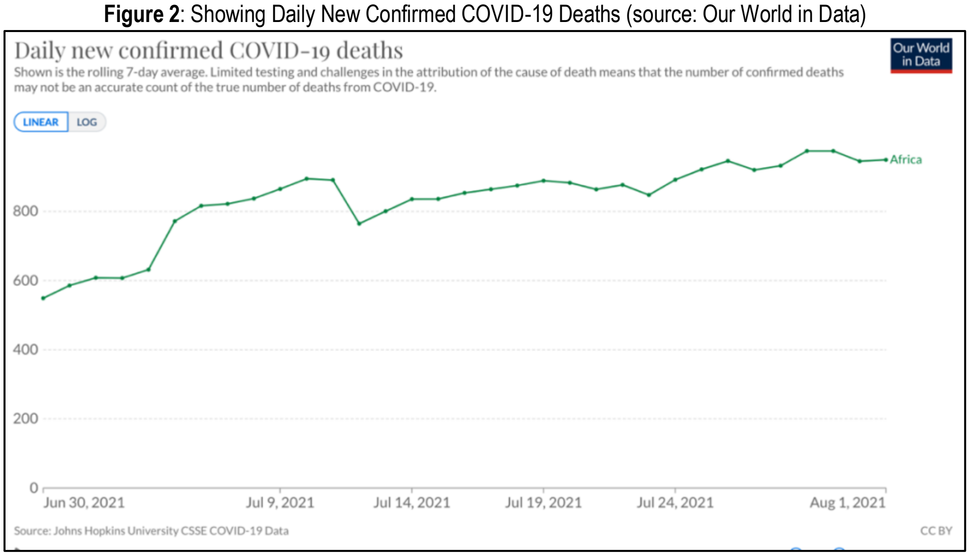


Figure 2: Showing Daily New Confirmed COVID-19 Deaths (source: Our World in Data)



Following trends from the month of June, cases (Figure 3) and deaths (Figure 4) were primarily concentrated in the southern region of the continent. South Africa, once again, surpassed all other African countries, reaching a peak of 19,766 new confirmed cases on July 8, 2021, and 419 confirmed deaths on July 26.

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

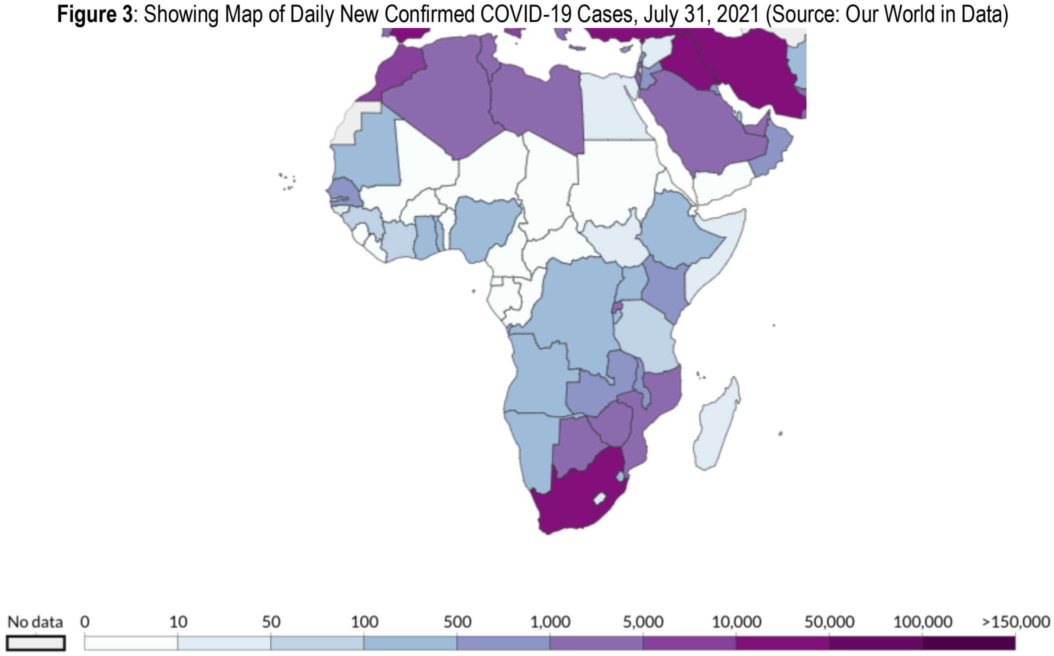
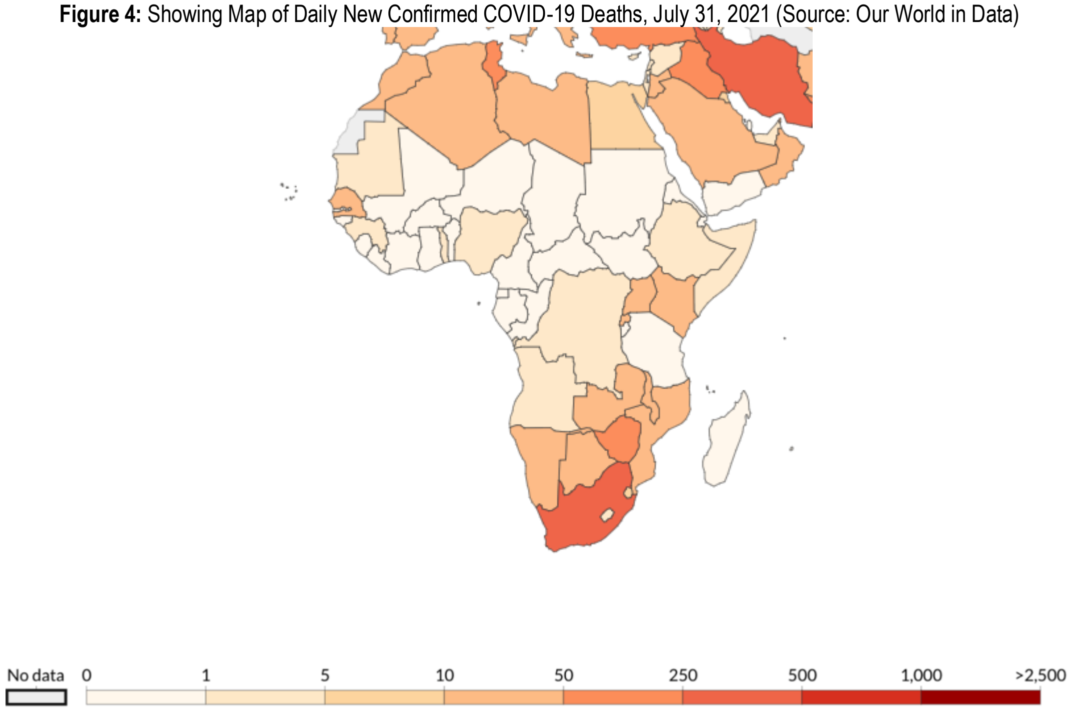


Figure 4: Showing Map of Daily New Confirmed COVID-19 Deaths, July 31, 2021 (Source: Our World in Data)

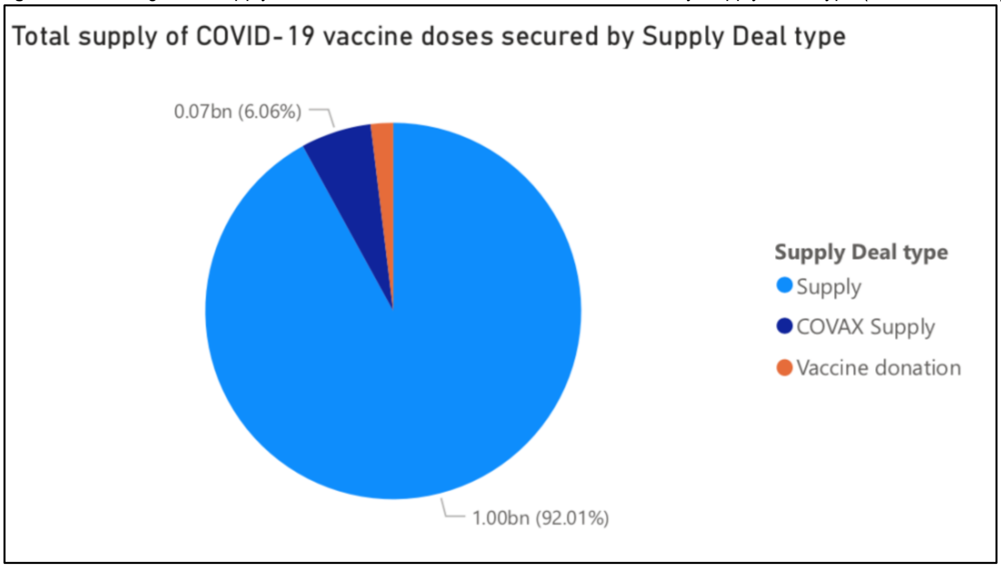


VACCINE ROLLOUT

Across the continent, 1.1 billion vaccine doses had been secured by the end July. Of those, roughly 81 million doses had been delivered by the end of the month. Of the 4.7 billon doses delivered globally, a meagre 1.7% have gone to Africa.

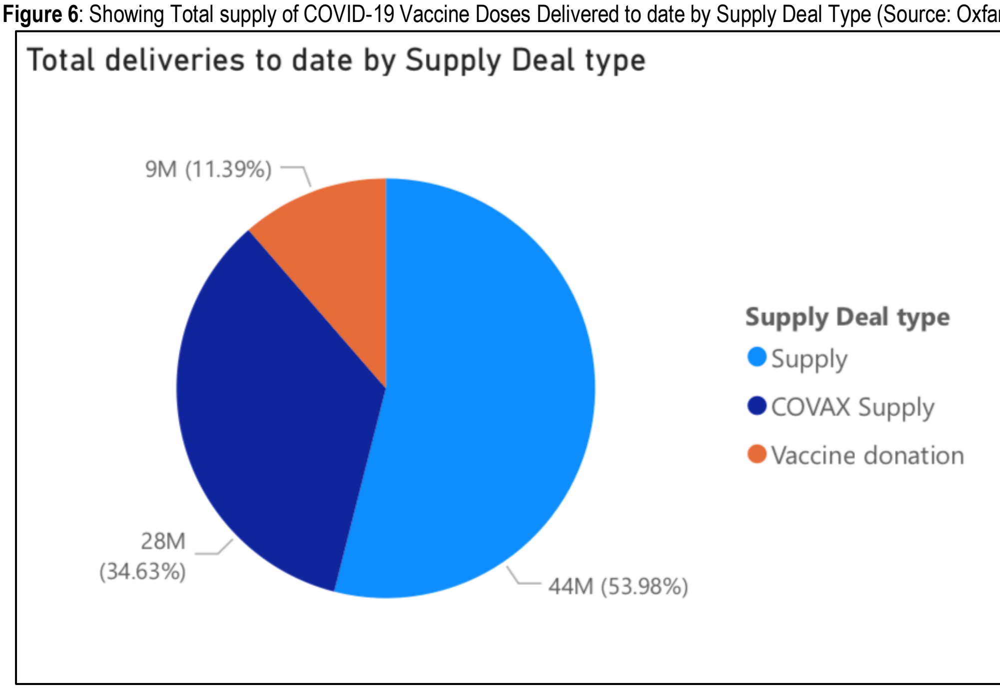
Following trends from the previous month, the African Union (AU) secured the greatest number of doses (1 billion doses, 92.01%), followed by COVAX (0.07 billion doses, 6.06%), and vaccine donations (1.93%) (Figure 5). Bilateral deals, once again, accounted for the highest number of delivered doses (44 million) (Figure 6).

Figure 5: Showing Total supply of COVID-19 Vaccine Doses Secured to date by Supply Deal Type (Source: Oxfam)



Note: Supply refers to Bilateral Supply.

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



Note: "Supply" refers to Bilateral Supply.

Johnson & Johnson accounted for the highest secured supply of COVID-19 doses (465 million doses), followed by Sputnik V (332.5 million doses), Pfizer (103.1 million doses), and AstraZeneca (101.6 million doses) (Figure 7). Sinopharm (BBIBP) was the most widely used vaccine in the continent, accounting for 29 million of the total delivered doses, followed by AstraZeneca with 24 million deliveries to date (Figure 8).

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

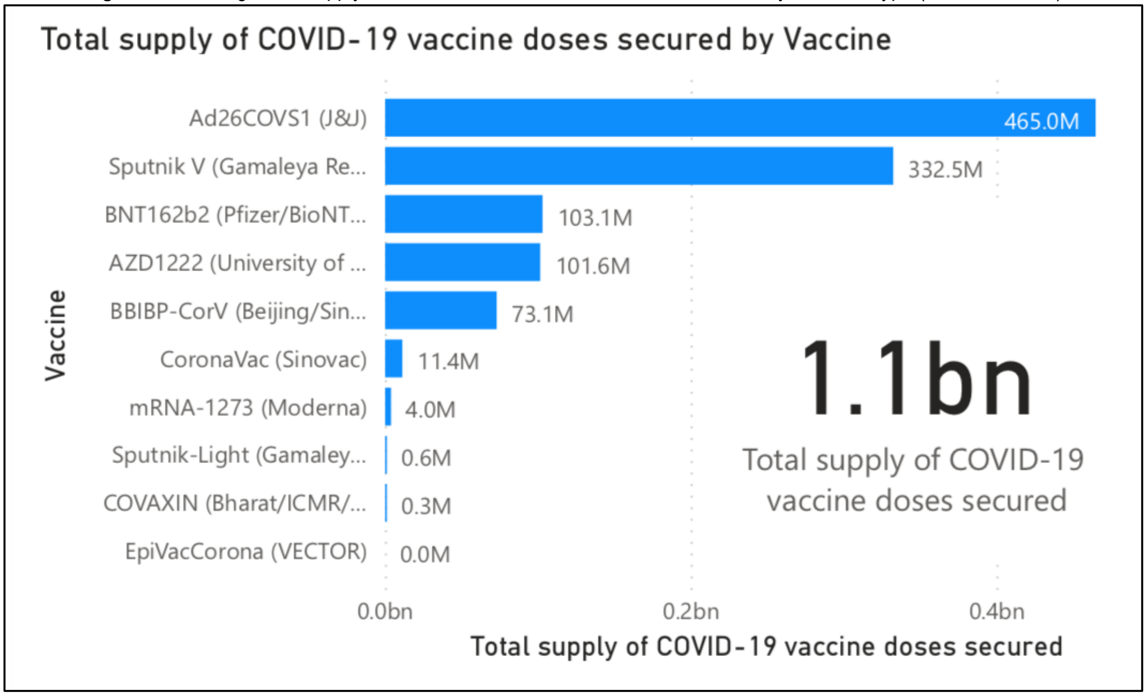
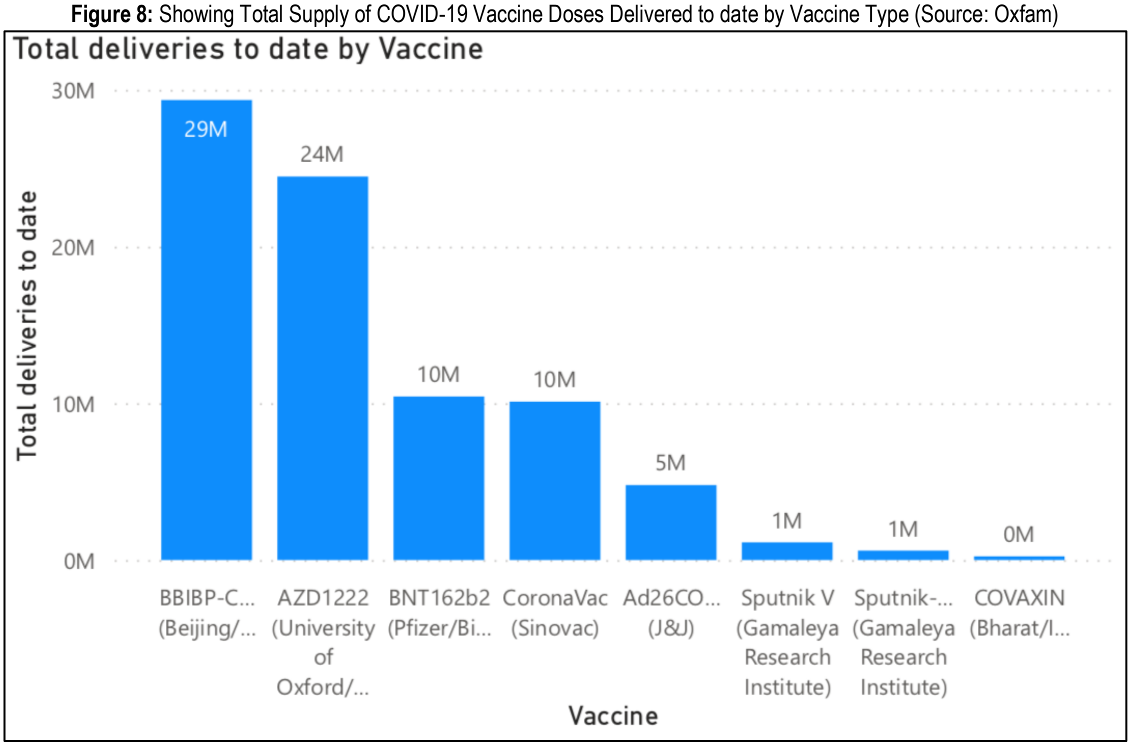
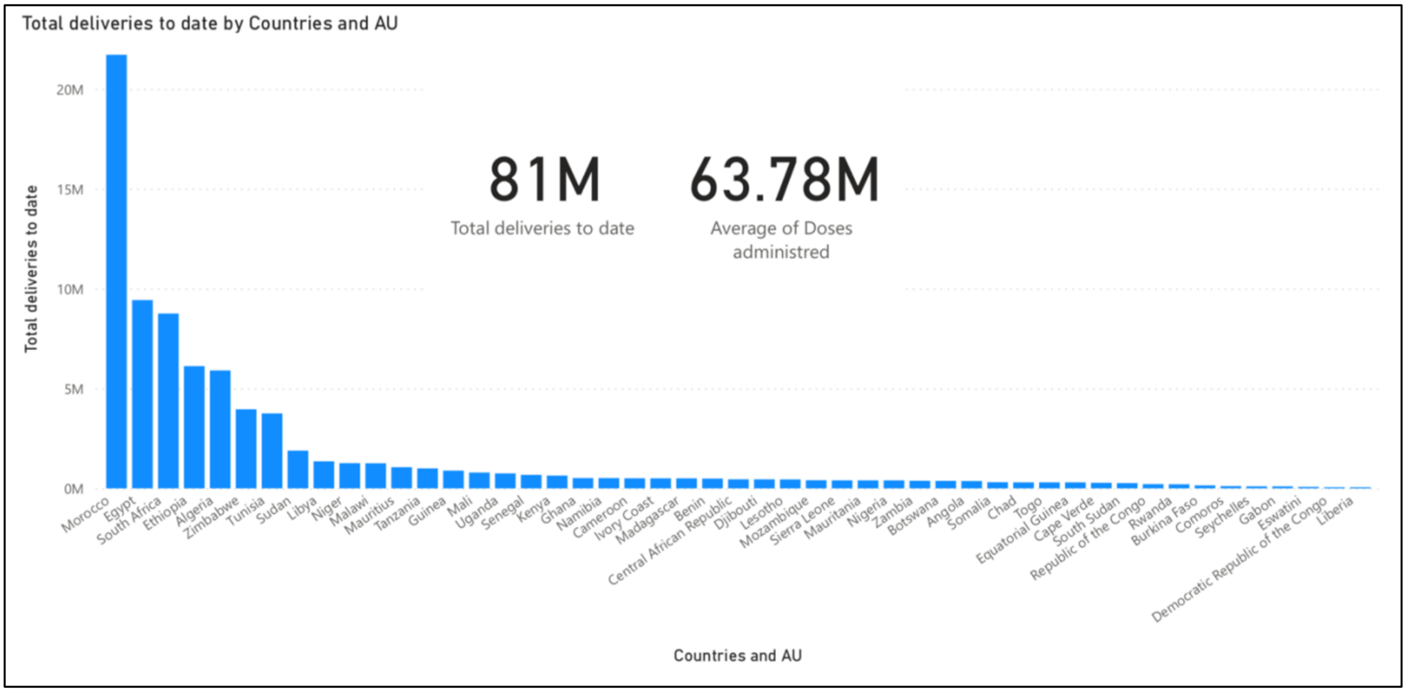


Figure 8: Showing Total Supply of COVID-19 Vaccine Doses Delivered to date by Vaccine Type (Source: Oxfam)



By the end of July, Morocco had, once again, received the most doses (20+ million), followed by Egypt(~9.5 million), and South Africa (~9 million) (Figure 9). 63.7M doses have been administered in Africa, which is 1.7% of the more than 4.01 billion doses administered globally.

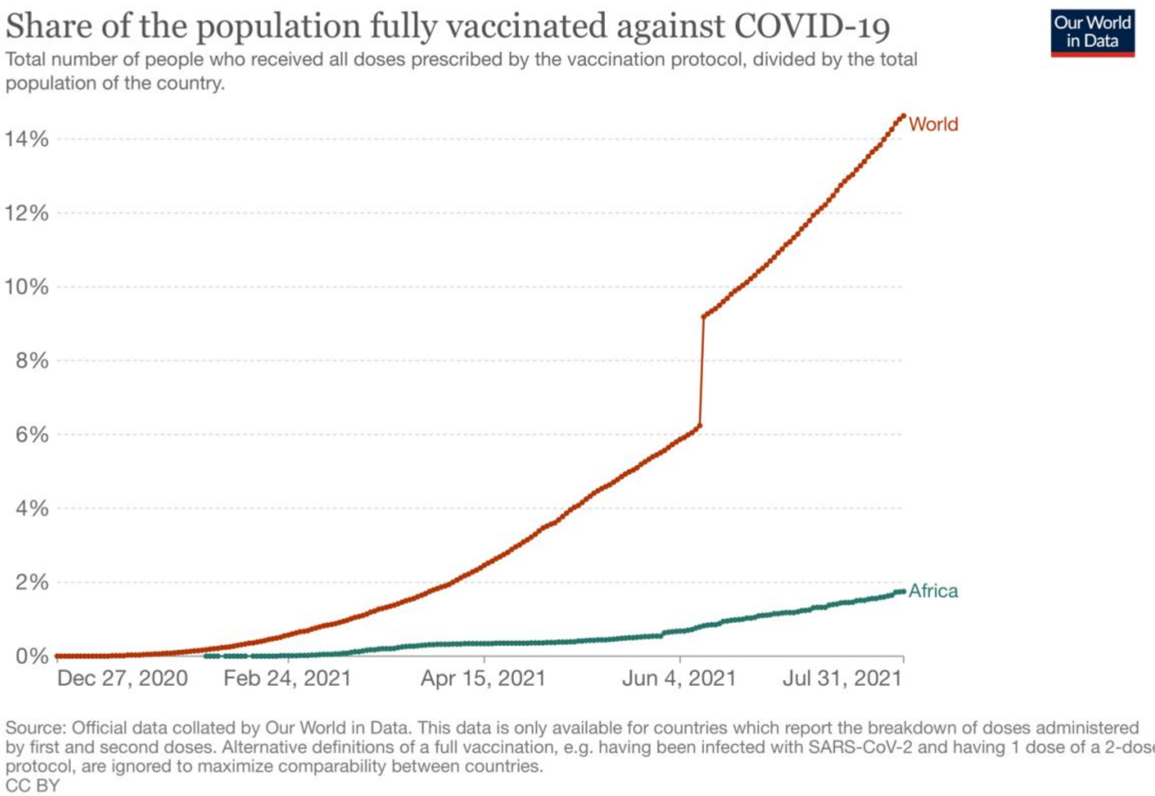
Figure 9: Showing Total Vaccine Deliveries to date by Countries and AU (Source: Oxfam)



Vaccine inequity persisted within the continent in July, with Mauritius, Morocco, Saint Helena, and the Seychelles leading in vaccination efforts (greatest percentage of population vaccinated), while countries like Burkina Faso, Chad, the Democratic Republic of the Congo, Guinea-Bissau, South Sudan, and Uganda had still vaccinated less than 0.1% of their population.

The striking disparity between the percentage of people fully vaccinated in Africa vs those fully vaccinated across the world has worsened since last month. Since June, the percentage of people fully vaccinated globally has risen from 11% to 14.5%. However, in Africa, we are still at a dismal 1.7% of fully vaccinated individuals, up only a fraction since June 30. (Figure 10)

Figure 10: Showing Percentage of Population Fully Vaccinated Against COVID-19 Globally vs in Africa (Source: Our World in Data)



COMMENTARY FROM AROUND THE CONTINENT

COVID-19: A pandemic that Changed Everything

By Lois Chingandu
July 31, 2021

When the first wave of COVID-19 hit many parts of the world in 2020, it looked as if the gods had decided that Africa had enough problems and will be spared. Many attributed this temporary reprieve to religious beliefs and traditional beliefs that many Africans hold. We often use those to explain misfortunes and successes in our lives when there is no clear scientific explanation. One minister from my country called it "a disease for the West and rich people." She was later proven wrong when a number of high-level civil servants and ministers in the Zimbabwean government died of COVID-19 in a span of two weeks. A year later, the Delta variant that is sweeping through Africa has taken away all notions that anyone had of thinking that we were not going to be severely affected by this deadly pandemic.

Everyone in my network has been touched by COVID-19. In December 2020, it looked like I was about to lose my husband, my mum, my daughter (and maybe even myself) all in the space of one week, as the whole family was infected by the virus. I will never forget the fear and the desperation that I felt when I was told that all hospitals in Zimbabwe were full and there was no oxygen – this when both my husband and daughter desperately needed it. Blessed with privilege unavailable to many others, they were airlifted to South Africa for admission into two different hospitals. We all survived and struggled with long COVID for months afterwards, which was a small price to pay in comparison to that paid by many of my friends and other relatives who were not so lucky. They died in large numbers.

I was an activist and an advocate in the 1980s when we were fighting to have equal access to affordable HIV treatment. For many years, millions of Africans died from HIV while people in developed countries were already living positively with the virus. After years of fighting and seeing courageous activists die before they could access treatment, we finally won. Millions were saved and live healthy HIV positive lives today. I was grateful that it had happened in my lifetime and hoped I would never have to witness that again. People should never have to put a price on their lives to access the same treatment that other human beings have, the way it happened with people with HIV in Africa.

When the COVID-19 vaccine was announced within a record period of 180 days, I was relieved and impressed with the ability of our scientists to find a solution to COVID-19 so quickly. I don't know why I was naïve enough to think that Africans would have access to the vaccines at the same time as everybody in the Global North. Having lived through the HIV era of fighting for the removal of patency and profits and watching so many people die of AIDS years after treatment was available, I should have known better. In my defence, I had actually believed the calls for global solidarity, the sustainable development goals, and the rhetoric around human rights. I thought that we were witnessing a new era of leaders who value and strive to achieve equality in all aspects of human life everywhere. I was wrong.

During the period of research and development of the vaccines, rich countries paid billions of dollars to several pharmaceutical companies to buy up doses, before effectiveness had even been proven. I understand the need to plan ahead, but hoarding is unjustifiably selfish and puts everyone at risk of variants. But, it happened, and it is part of the reason why African countries – even those with money - are unable to find vaccines to purchase.

As the deadliest impact of COVID-19 wanes in rich Western countries, it is rising in African countries at an even higher rate than before. Vaccinations are way below the expected levels and only 1 in 10 people in the Global South will be lucky to be vaccinated by the end of this year. To date, COVAX has only provided 4% of vaccine shots administered globally against the expected target of 27%. Recent pledges from G7 leaders to share vaccines fall far short of the 11 billion doses needed to reach a global headcount. According to an analysis by ONE Africa COVID Tracker, the world's richest countries could still have 2 billion doses to share after vaccinating their entire population. This is enough to vaccinate the entire adult population of Africa. It baffles the mind to understand why they are still hoarding all of those doses when African countries have reported that they have run out of the few doses that they had secured or received as donations.

Thirty years after our struggle for ARV justice, we are – in collaboration with partners around the world, including the People's Vaccine Alliance and the African Alliance – once again fighting a war against the greediness of big Pharma and the indifference of governments. Our demands are the same as those we put forward in the eighties. We are getting the same responses, the same small and insufficient steps, and the same excuses. It is exhausting, frustrating, and infuriating to see this happening in my lifetime yet again. Profits should not come before lives.

A few weeks ago, COVID-19 struck again and killed my childhood friend and the husband of my best friend. I fell into a deep dark hole, in which I felt helpless and useless as an advocate and activist. I curled up in my bed and cried for days. I am an activist: I fall and I stand up, dust myself off and join the rest of the voices shaming Pharma for choosing profits over our lives. There is no one country that can produce enough vaccines to meet the demand that exists right now. Corporations and rich countries need to stop protecting monopolies, remove barriers that restrict production, share technology through C-TAP, and lower prices to allow all countries to produce vaccines locally for their own populations. The immediate solution is for the rich countries to share their excess doses with the Global South.

We can only return to 'normal life' if we all get vaccinated. The current situation is immoral and untenable. We call upon world leaders to do step up to their responsibilities. #StopPlayingGames with our lives.

Lois Chingandu *is a nurse midwife, HIV, gender & SRHR advocate, activist and author with over 25 years of hands-on and leadership experience advocating for the rights of People Living with HIV, Women and Girls and marginalised key populations in Sub-Saharan Africa and Globally. Due to her extensive experience in the HIV sector, Lois is recognised as a global thought leader on HIV Gender and Social Justice issues in Sub-Saharan region and has served as a member of various think tanks and platforms such as the UN Secretary General Taskforce on Women and Girls, UN Human Rights and Social Justice Taskforce, UN International Monitoring and Evaluation Resource Group (MERG) and the SAA Board for ICASA. Lois started working in the HIV field in the eighties and has experienced the different waves of the HIV response before treatment, with treatment and now in the face of COVID-19. Lois has worked from the community level overseeing homebased care to the national level advocating for better policies and the global level calling for universal access to life saving antiretroviral treatments. She is currently the Director of Evidence and Influence at Frontline AIDS Global. This is an original piece written for publication in this report.*

Whose Vaccine Justice? Debating Covid-19 Immunization in Sierra Leone
Luisa Enria, Anthony Mansaray, Mahmood H. Bangura and Alie Timbo
July 12, 2021

Growing fears of a "third wave" of Covid-19 across the world have intensified discussions about vaccine inequity, as some nations find themselves better prepared to combat rising infections than others. Hoarding of doses by high income countries, export bans and resistance to waiving patents to enable wider vaccine manufacturing are leading to what the WHO's Director General called "vaccine apartheid". Whilst countries like the United Kingdom have fully vaccinated over half their population, only about 1% of the population on the African continent has been fully vaccinated. Initiatives like COVAX, which aim to support equitable vaccine access, have been underfunded and pledges made at the G7 meeting in early June fell significantly short of the amounts of doses required by the WHO. COVAX's aim to vaccinate just over 20% of each participating country's population by the end of 2021 is not only insufficient to protect the world against the emergence of new variants. The charity model has also been critiqued for being inadequate, reproducing inequalities and failing to acknowledge and address deeper injustices in global health. African Union envoy Strive Masiyiwa, for example, pointed to a deliberate moral failure, suggesting that African leaders were "misled" into "believing that the whole world was coming together to purchase vaccines, not knowing that we had been corralled into a little corner while others ran off and secured the supplies". Similarly, a European policy that would not allow people vaccinated with AstraZeneca vaccines manufactured in India (which constitute the majority of COVAX doses) entry into Europe has raised new questions about how vaccine inequity is linked to other exclusionary practices. The debate over vaccination, in other words, is opening up bigger conversations about definitions of global solidarity, including recent calls for a reframing of the issue as one of reparative justice as well as detailed discussions about how manufacturing capacity might be scaled up in African countries.

Debates on vaccine equity often appear technical, focused on diplomacy or obscure intellectual property law. As this topic becomes increasingly central to how we define contemporary global justice, we should also ask who gets to define the parameters of vaccine development and deployment, and where the space for public debate begins and ends. Often when it comes to vaccination, policymakers only imagine the role of the public through concerns about potential hesitancy. Of course, vaccine confidence is extremely important, especially when rolling out a vaccination campaign during a health emergency. Yet the spectre of "refusal" can often obscure the much more complex reasons and conditions that build or undermine trust in vaccine deployments in times of crisis. At this critical juncture, then, how can we re-imagine what vaccine equity looks like, and what the role of the public might be in that debate? In particular, how can we redefine the contours of vaccine justice to bring together questions of vaccine development, supply, access and confidence in public deliberations? Some experiences from Sierra Leone that we have been documenting since the last Ebola outbreak through to today's Covid-19 pandemic offer some insights that we believe hold important lessons for global discussions.

Over the last year Sierra Leone fared comparatively well in facing the Covid-19 pandemic, registering relatively few cases and deaths until a recent spike in early June 2021 associated with the arrival of the Delta variant amongst a mostly unvaccinated population. In March this year, Sierra Leone received its first COVAX consignment of 96,000 doses out of 528,000 pledged, and 42,000 doses of AstraZeneca from the African Union, whilst the Chinese government donated 200,000 doses of the Sinopharm vaccine. These doses are nowhere near enough to cover the country's 7.8 million population. At the same time, officials such as the recently appointed Minister of Health Dr Austin Demby expressed concerns about potential challenges in uptake, fearing that some of the currently available doses may go to waste. This sparked additional efforts by District Health Management Teams (DHMTs), which are allocating more funds to reinforce the uptake of the AstraZeneca vaccines that are closer to expiration period. In communities across Sierra Leone, discussions have been ongoing about how to best control the disease if it starts overwhelming the system. There, lessons from Ebola are proving valuable as public health officials and civil society alike re-activate their expertise and networks of response. Memories of Ebola however also act as reminders of the challenges of gaining public trust in a health emergency, as similar anxieties re-emerge around the nature and veracity of Covid-19 alongside concerns about the social and political implications of public health regulations.

To think through these challenges, we are inspired by conversations we have had over the last few years with participants in the Ebola vaccine trials, district public health officials, community health workers and the general public in Kambia District (North Western Sierra Leone) about all aspects of the vaccine deployment process, from development to delivery. From these conversations, we consider three key lessons to be particularly important for re-imagining public engagement in the current challenges the world faces to bring Covid-19 under control and to become prepared for future infectious disease outbreaks.

Participation in vaccine development

The first lesson concerns the value of involving both participants and the general public in shaping the processes through which vaccines are developed. Clinical trials are a key component in vaccine development as they make it possible to test either the efficacy of or the immune response generated by novel vaccines. Engaging with those who chose to participate in the trials of the Ebola vaccine at the tail-end and immediate aftermath of the epidemic in Sierra Leone highlighted deep uncertainties and in some instances mistrust in both government and international humanitarian workers, including questions about profit motives not dissimilar to those being raised by critics of the current vaccine dispensation. These discussions also highlighted a wide range of motivations for deciding to contribute to the development of vaccines. Some of these included feelings of citizenship and a wish to sacrifice for the nation in a moment of crisis, as well as hopes of accessing better healthcare opportunities. Public perspectives on trials should not however be limited, as they often are, to questions of recruitment of participants. Expanding the space of public engagement would allow us to consider how the design of clinical research itself might better include citizen voices. In Sierra Leone this included listening to perspectives on trial procedures such as randomization or exploring how local economies might determine deliberations on reimbursement, or participants and ideas of what fairness looks like. Embedding vaccine research in the communities where it is taking place, particularly in times of crisis where uncertainty is rife and the stakes of medical research are high, should be a key first component in an expanded vision of vaccine justice.

Confronting mistrust

A second lesson is around how to directly confront the thorny question of mistrust. Our studies on perspectives of Ebola, and more recently Covid-19, vaccines have made clear the importance of taking seriously specific and often legitimate concerns that people have around novel vaccines. In our experience, there are two aspects to this. Firstly, we need to acknowledge that vaccine confidence cannot be disentangled from mistrust in the broader health system and political institutions, including international bodies. In this sense, this is not a problem with a quick fix. In our research with Community Health Workers on vaccine hesitancy in Kambia's border communities, we saw how everyday interactions with healthcare workers, and particularly feelings of marginalisation and even humiliation, and the reality that the wealthy have priority to access health services, were affecting willingness to turn up for vaccination appointments. With trust in vaccination so closely related to structural inequalities in access to quality healthcare, including long-term defunding of health services through international policies, questions of access and demand seemed harder to disentangle. Similarly, fears surrounding both the Ebola and Covid-19 response, and particularly concerns that these epidemics may be "man-made" with an intention to decimate African populations, pointed to much longer-standing fractures in state-society relations as well as concerns about predatory Western interests. Secondly, however, whilst the deep roots of mistrust need to be attended to, when asked directly about their perspectives on vaccines, our interlocutors often raise very specific concerns about the safety of new vaccines or concerns about potential side-effects. Engaging the public in debates about vaccine confidence, then, means approaching the challenge as a multi-dimensional issue, directly addressing specific concerns but also paying attention to the drivers of mistrust outside of the vaccine encounter.

Engaging publics in deployment decisions

Thirdly, once a vaccine has been developed, considerations of how it is deployed, particularly in emergency situations, are rarely considered to be a topic for public discussion. However, our research has shown at least two areas where citizen engagement with logistical and ethical questions around deployment could make important contributions. To begin with, experiences with routine vaccination have shown how strategies for delivering vaccines to the population can at times not be well matched to the everyday realities faced by different groups. For example, in Kambia's border areas, vaccination campaigns needed to be better aligned with farming schedules and trading obligations in neighboring Guinea. Questions of access are just as important for Covid-19 vaccination, as the number of distribution points in Sierra Leone remain currently fairly limited and therefore require people to travel to receive a dose. In Kambia, for example, only two static points were established, and one mobile team has been tasked to rove around the District. These limits may not only limit first dose uptake but may pose a challenge to completion of the second dose. Indeed, discussions we have been holding across rural communities in Kambia have led to rich debates about the logistics of vaccine deployment. In one village, for example, participants told us that if given a choice they would prefer "pop up" vaccination centres near their homes, not only for ease of access, but because seeing neighbours and respected local authorities taking a Covid-19 vaccine would strengthen their confidence. These discussions also contended with difficult ethical issues, including what to do about limited supplies—where some participants argued that they would rather have only one dose if it meant that more people in the community could be protected, even if it meant lower efficacy. Similarly, in a village that had experienced extended, militarized confinement during the Ebola outbreak, a lively discussion on Covid-19 vaccines raised new questions around the ethics of prioritization: should elders be prioritized because they are more at risk from Covid-19, or should young people rather have first access because they need to work? An elderly chief for example argued that his generation had already lived their lives as he proposed that perhaps the young should be given protection first. These discussions at the village level mirror the kinds of questions that global vaccine inequity poses and what deliberating on solidarity might look like.

These three lessons highlight the specific questions that emerge for those in charge of deploying vaccines in Sierra Leone. However, they also show that existing global debates on the parameters of vaccine equity have restricted the remit of public engagement to their detriment. Global inequities in vaccine supply have sparked new contestations of historical and contemporary injustice, opening up the space to imagine new possibilities. As we continue to advocate for expanded vaccine supply and access, including through Intellectual Property waivers, knowledge transfers and scaling up manufacturing and delivery mechanisms, we should also expand our understanding of vaccine justice and open up the space for who gets to define its parameters. Our conversations in Sierra Leone point to the importance of bringing together questions of supply and demand, equity and confidence, and to involving citizens in the ethical, logistical and political debates that underpin the whole vaccine process from development to delivery. Public debates on these issues are already happening: they are visible in both anxieties and hopes that circulate around vaccination, in popular critiques and everyday exchanges about what quality healthcare should look like or in deliberations around the ethics of medical research and emergency vaccination in times of crisis. It's time that global leaders listened.

***Luisa Enria** is Assistant Professor at LSHTM, where her research focuses on experiences, imaginations and contestations of development, humanitarianism and health emergency responses, including vaccine development and deployment, in Sierra Leone. She currently holds a UKRI Future Leaders Fellowship titled "Crisis of Confidence: The Politics of Evidence and (Mis)trust in Epidemic Preparedness". **Anthony Mansaray** is a Social Science Research Fellow at LSHTM, where he works on the Ebola vaccine trials in Sierra Leone's Kambia District. Anthony holds an MSc in Global Health & Development from University College London (UCL) and has extensive experience in managing both quantitative and qualitative social science research projects in Sierra Leone, Liberia and Ghana. He has worked for various organizations including Christian Aid, ICAP at Columbia University and Innovations for Poverty Action. **Mahmood H. Bangura** is a Social Science Researcher at the College of Medicine and Allied Health Sciences (COMAHS) in Sierra Leone. He has worked on the Ebola vaccine trials for the last six years, first as a research assistant, now as a graduate researcher. He is also an MSc student in Sustainable Development at the University of Makeni, Sierra Leone. **Alie D. Timbo** is a Social Science Research Assistant at the College of Medicine and Allied Health Sciences (COMAHS). He has worked on a number of qualitative research projects, including recently on epidemic preparedness and vaccine confidence. He has a BSc in Peace and Conflict Studies from the University*

*of Sierra Leone, Fourah Bay College and a decade of experience consulting for various NGOs, development consulting firms and public health bodies. This piece was published in **African Arguments**.*

AFRICA MEDIA ROUNDUP

COVID-19: Uganda's Route Out is Obvious
African Arguments (Pan-African)
July 6, 2021
By David Mafigiri & Megan Schmidt-Sane

Despite previous public health wins, Uganda has struggled with the Delta variant of COVID-19. Though Uganda's early response to COVID was successful, no response today is appropriate without a comprehensive vaccine response. Like every other African country, Uganda has been shoved into a corner of have-nots while wealthy countries continue to hoard vaccines. The article compares vaccination rates in the world, in Africa, and in Uganda.

COVID-19: Gauteng hospitals under strain as third wave continues
Spotlight (South Africa)
July 15, 2021
By Thabo Molelekwa

The third wave in South Africa has thrown the previous protocols out the window and experts recognize this wave is much more difficult to manage than the second. The overcrowding of hospitals is an issue that affects patient care and, ironically, vaccine rollout. Nurses who staff both hospitals and vaccination centres are under severe strain, leading to the province being unable to meet its vaccination targets, even in cases when vaccines are available.

Frustrated, now Africa proposes that vaccines be produced locally
The East African (Kenya)
July 27, 2021
By Pauline Kairu

After fruitless negotiations with COVAX, and a lack of vaccine availability for direct purchase from manufacturers, African Union leaders are pushing African manufacturing of COVID-19 vaccines. This article notes two deals (with Johnson & Johnson and Pfizer) which will allow for South African companies (Aspen and Biovac) to complete the tail-end of vaccine manufacturing (also known as "fill and finish"). Boosting production of COVID-19 vaccines around the world is an essential step towards addressing the crushing vaccine apartheid that is plaguing the African continent.

As Africa awaits next Covid19 vaccine supplies, WHO survey shows cold chain gaps persist
The Africa Report (Pan-African)
July 29, 2021
By Chinedu Asadu

As African countries continue to struggle with vaccine inequity, the cold chain necessary to maintain the dose from lab to arm has also proven to be difficult to maintain. Chinedu Asadu writes that a worrying number of doses have been lost in Africa due to the lack of infrastructure needed to keep the vaccines at the required temperature before injection. In turn, the cold chain gap contributed to a lack of confidence in Africa's ability to implement a successful continent-wide vaccine rollout program.