Aidspan
Independent observer of the Global Fund

COVID-19: ARE WE WINNING? YES AND NO!

I finished my quarantine in my Waterloo apartment a week ago. I had three days confined in an airport hotel and then 11 more in Waterloo. The government was efficient at checking up on me. Every day I got an automated email with a weblink, and had to complete a form online. There were at least two phone calls and one visit from a private investigator, who had been repurposed as a quarantine inspector, complete with stab proof vest. He came to the door of the apartment, but said he was not allowed to enter it – which somewhat defeats the objective of checking.

COVID-19: The numbers

Globally, as of 1st June there had been 170,784,945 cases and 3,551,570 deaths. The graphs show the number of new cases has fallen over the past few months while the number of deaths has been constant. The positive news is that the number of vaccine doses administered has reached 1,925,890,969, a remarkable achievement, and one where the numbers continuing to climb is a 'good' thing.

The largest number of cumulative cases continues to be reported by the USA, at over 33 million cases and about 600,000 deaths, but the rate of increase has slowed. India has the second-highest caseload and is catching up with the US. It has about 28 million cases and has recorded about 350,000 deaths. Brazil is third with about 16.5 million cases and over 450,000 deaths and numbers continue to climb. France is fourth with nearly six million cases followed by Turkey, Russia, and the United Kingdom. In all these countries, except Russia, the number of cases and deaths continues to fall. Indeed, the UK reported deaths in single figures over the past few weeks and even days when there were no deaths.

European countries such as Germany, Italy and Spain, and South America's Argentina and Colombia, have between three and five million cases. All other countries have fewer. In South Africa, there have been 1,665,617 cases and 56,506 deaths and in Canada 1,389,328 cases and 25,528 deaths. The case

fatality rate in Canada is much lower than that of South Africa.

Despite the lower number of cases in most African countries, the continent has the highest death rates among critically ill COVID-19 patients. A recent study reported in The Lancet notes that, due to the lack of data on critically ill patients with COVID-19, and factors associated with death or survival, they conducted observations on patients referred to intensive care or high-care units from May to December 2020 in 64 hospitals in ten countries — Egypt, Ethiopia, Ghana, Kenya, Libya, Malawi, Mozambique, Niger, Nigeria and South Africa — to identify death or survival rates and associated factors. (Africa has about two percent of reported COVID-19 cases).

“Of the 3,077 critically ill adults in the study who were followed up for at least 30 days unless they died or were discharged, 1,483 (48.2 percent), died”, the study says. “We expected the outcomes associated with COVID-19 to be worse in Africa because we have a limited workforce, and we have limited intensive care facilities and critical care resources across Africa to provide sufficient care.”

“It is unacceptable that people should have a higher [chance of] mortality, just because of where they live. We need to advocate for quality healthcare in Africa, and other under-resourced environments. The burden of poorly managed COVID-19 has a long-term impact [on] quality of life, productivity and economics,”…

According to the study, Africa’s death rate of 48.2 percent is higher than the global average of 31.5 percent and that of other regions including Asia (29.6 percent), Europe (31.5 percent), and North America (33.8 percent)”.

The reasons identified for this are poor health care and a lack of minimum standards. A modelling study at the beginning of COVID-19 showed Africa had approximately one bed per 100,000 population and many patients did not receive adequate monitoring because of limited resources, in some cases they were poorly maintained, non-functional or redundant. There are not enough beds or staff and the only way forward in the short term is vaccination. In addition, essential medical services have been interrupted and medical supplies and expertise have not reached the patients who need them most.

A key question is what will happen to COVID in Africa. Will the Indian situation be replicated? It seems unlikely this will happen across the continent, but it might be the case in some crowded poor urban settings. It will be important to monitor the situation. The tragedy is that we lack decent data in so many settings that it may be hard to know what is going on and how, and if things are changing. The disease burdens in many of these countries are already high. Africa needs low-cost, scalable, and effective interventions for improving healthcare outcomes, not just for COVID.

COVID and AIDS

Mark Heywood is well known in South Africa (and around the world) for his leadership in the fight against HIV and AIDS. In this article from the Daily Maverick he asks why AIDS is still here 40 years later, and why we seem to have learnt so little from it in the response to Covid.

“In the past 20 years we were able to make strides against HIV because of the efforts of activists, who demanded access to HIV treatment and prevention as a human right. But despite the progress it hasn’t stopped people from being infected and dying”.

He concludes that AIDS is still here because of: broken and underfunded public health systems; the pandemic of social inequality and especially gender-based inequality and violence; continued dictatorship of big pharma over medicine development and pricing; and loss of personal autonomy, dignity and freedom experienced by millions as a result of hunger, migration and marginalisation.

Heywood notes that “Unless society acts decisively both (AIDS and COVID) could be with us for years to come; indeed, they will probably still be around when the next big pandemic comes”.

He calls for health and human rights activists to regroup to chart a path to end COVID-19 and AIDS. This brief article is important but is it realistic?

As is so often the case, activists and human rights organisers have failed to address the elephants in the room. The larger elephant is called ‘the cost and who will pay for interventions’, the smaller but no less important elephant is ‘who cares’. The irony is the smaller the larger elephant is the easier it is for people to care. We desperately need activists; the TRIPS waiver being supported by the Biden administration is significant. The ‘Report of the Independent Panel for Pandemic Preparedness and Response: making COVID-19 the last pandemic’ offers a way forward but as Heywood notes this won’t happen without a global campaign. ‘Across the world civil society needs to adopt the plan, break its parts down into demands and give it content’.

There was a promising sign that this was starting to happen when, on 10 May, the British Medical Journal published an Opinion signed by health and human rights activists across the world insisting that “an international pandemic treaty must centre on human rights”. However, the signatories were overwhelmingly from organisations working on health. Staying in our silos won’t break this nut! It is crucial that economists and Ministries of Finance are brought to the table. This is especially the case given the economic disruption the global economy faces. There is much to learn from AIDS but little sign this is happening.

Some Simplification Welcome

The media has reported that the names of COVID-19 variants are to change. Historically, diseases have been named after the locations they were first found or thought to have developed. This is often inaccurate and sometimes damaging – examples are the Ebola virus, which takes its name from the Congolese river, and the ‘Spanish flu’ of 1918, so-called because of numerous reports from there. Donald Trump incited anti-Chinese feelings by referring to COVID-19 as ‘the China flu’ and ‘Kung Flu’. India has strongly objected to the naming of the ‘Indian variant’ and ordered social media platforms to take down content that referred to this. In South Africa there was a feeling that the South Africa variant was actually the British Variant.

The World Health Organization announced on Monday 31 May 2021 that a new naming system has been devised. The variants will be given names from the Greek alphabet to both simplify the public discussion and to strip the stigma from the emergence of new variants.

“Under the new scheme, B.1.1.7, the variant first identified in Britain, will be known as Alpha and B.1.351, the variant first spotted in South Africa, will be Beta. P.1, the variant first detected in Brazil, will be Gamma and B.1.671.2, the so-called Indian variant, is Delta”.

This really is to be welcomed and I will adopt this system now. The increased number of cases of the Delta variant in the UK seems to be placing the comprehensive unlocking under peril. It will be very fascinating to see how this will play out over the next few weeks.

Conclusion

Traveling from the UK to Canada, spending two weeks in quarantine and then trying to work out what Ican and can't do has been fascinating. The one thing I am sure of is that it will take a very long time forthere to be any return to pre-pandemic lifestyles. I am certain there will be less travel and fewer aircraftflying. Airfares are set to increase as a result.

The way people shop and socialize will change. There will be a shake-up in job markets and I am not sure what this will look like. The real danger is fear. Fear of each other, and all contact. I have heard from friends with small children of their lack of socialization. After all, if a child spends the first 18 months of their lives in the company of only their parents and siblings they will be disadvantaged. What is most troubling is that this is neither recognized nor planned for.

Tools

Financial planning is crucial for the COVID-19 vaccine rollout. Millions of vaccine deliveries are planned for later this year and African countries must urgently plan ahead to quickly roll them out and avoid unplanned costs. The World Bank estimates that each month of delay in the provision of COVID-19 vaccines could cost Africa $ 14 billion in lost gross domestic product. For every dollar spent on buying vaccines, around 60% is needed for supporting operations. The COVID-19 Vaccine Introduction and Deployment Costing Tool is key to helping countries determine their funding needs and can help unlock more funds for the rollout of COVID-19 vaccines. There is a report from the WHO on this and a link to the tool.

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This piece is taken from Alan's last blog post, they are posted every two weeks at www.alan-whiteside.com

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