Status of COVID-19 in Supported Countries of East, Central and Southern Africa

13th March-23rd April 2020
East, Central and Southern Africa Health Community

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Introduction

China reported occurrence of pneumonia of an unknown cause to the World Health Organization on 31st December 2019. On 7th January, experts in China reported the pathogen was a hitherto unknown strain of the family of coronaviruses which was later found to be genetically closely related to the corona virus that was responsible for severe acute respiratory syndrome (SARS) of 2002 and 2003 and named SARS-CoV. The new virus was therefore aptly named SARS-CoV-2, causing a syndrome that has been named COVID-19 (short for coronavirus disease of 2019). It has been responsible for an illness that in its mild form mimics ordinary flu—mild fever, some coughing and headache; in its severe form it presents with pneumonia, and in its critical form it may cause multiple organ failure and death.

Starting in China, COVID-19 has spread to all continents but Antarctica and 210 countries and territories, and as of 23rd April 2020 infected over 2544792 people and killed not less than 175694 of them1. WHO declared it a Public Health Emergency of International Concern on 30th January and a pandemic on 11th March 2020. In response, countries have implemented necessary quarantines and social distancing practices as part of the strategy to limit its spread. This has impacted economic activities of countries and livelihoods of individuals. According to the International Monetary Fund (IMF), the current Great Lockdown is the worst recession since the Great Depression of 1929-19392.

The East, Central and Southern Africa Health Community (ECSA-HC) is an inter-governmental organization whose membership includes Eswatini, Kenya, Lesotho, Malawi, Mauritius, Tanzania, Uganda, Zambia and Zimbabwe. It supports multi-faceted health programs to improve the health status of populations in member states, and also with a footprint in neighbouring countries in the eastern and southern regions of Africa. To inform its planning to support preparedness and response to the COVID-19 pandemic in the supported countries, ECSA-HC has collated data on COVID-19 burden in Eswatini, Kenya, Lesotho, Malawi, Mauritius, Tanzania, Uganda, Zambia and Zimbabwe, Mozambique, Burundi, Rwanda and South Sudan, broadly reflecting the geographical span of most of our activities (map: https://datawrapper.dwcdn.net/NttBg/2/).

Purpose: to assess the magnitude of the burden of COVID-19 in the ECSA-Members States and States supported by ECSA-coordinated projects so as to identify elements in the countries’ health systems that need to be supported.

1 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports
2 https://www.google.com/search?client=firefox-b-d&q=imf+announcement+on+recession
Objectives: i) Document the total incidence of confirmed COVID-19 cases in the named countries; ii) describe the mortality due to COVID-19; iii) identify challenges faced during the preparedness/response efforts and iv) suggest interventions.

Methods:

Extraction of data from internet sources:

Since 13th March, a team at ECSA-HC has been extracting data on the progress of COVID-19 pandemic from reputable online sources, World Health Organization and available country reports. Data are collated at 9:00 am, 5:00 pm and 10:00 pm every day. If data change and are recorded later than that time, they are considered as part of the following day. Two major sources are: Johns Hopkins Coronavirus Resource Center³ and worldometer info/coronavirus⁴. Country and WHO (including its sitreps) reports provide additional sources.

In each country, a contact person was identified to serve the role of clarifying data received from other sources. Verification is achieved through telephone/Whatsapp/videoconferencing where the contact person provides answers to clarify data on incidence and deaths of reported cases.

Data management: The aggregate data collected were tabulated and provided the basis of the graphs and tables produced.

Ethical issues: Because the data collected were those available in public domains and no contact with human subjects was made, there was no concern for ethical issues.

Limitations: the data collected was aggregated and therefore provided no chance for any further analysis by other characteristics such as age or gender.

Supported Interventions

ECSA-HC communicated with project supported countries requesting them to provide a priority list of the assistance they needed to strengthen their response/preparedness to COVID-19 pandemic. After review ECSA-HC and some countries agreed on the feasible support that ECSA could provide within limits of available resources and the travel restrictions. Consultation with other countries continues.

The need for capacity building for health care workers on COVID-19 was expressed by nearly all countries. In view of existing restrictions on travel, ECSA-HC has:

³ https://coronavirus.jhu.edu/map.html
⁴ https://www.worldometers.info/coronavirus/
• Instituted online training for health workers in all supported countries through webinar sessions. A consultant was hired and the training sessions have been held twice a week since 14th April 2020 and will continue till 29th April 2020.

• In Lesotho, Malawi, Zambia and Zimbabwe, through the Southern Africa TB and Health Systems Support project (SATBHSS) ECSA-HC has organized in-person training using in-country trainers on identified areas of concern, including: surveillance at Points of Entry; infection prevention and control, contact tracing, case management and laboratory diagnosis.

• In Kenya, through the East Africa Public Health Laboratory Networking project, the organization is supporting capacity building for sub-national rapid response teams and expanding testing capacities—two of the EAPHLNP-supported laboratories (Wajir and Machakos) have been designated testing centers for their catchment regions for COVID-19.

• The requests for assistance from Zanzibar and mainland Tanzania are under review.
Findings:

This is the situation in the countries from 13th March to 23rd April 2020.

1. Reported confirmed cases of COVID-19 by country
2. Reported deaths by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Reported cases</th>
<th>Reported deaths</th>
<th>Recoveries</th>
<th>CFR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>11</td>
<td>1</td>
<td>4</td>
<td>9.1</td>
</tr>
<tr>
<td>Eswatini</td>
<td>31</td>
<td>1</td>
<td>8</td>
<td>3.2</td>
</tr>
<tr>
<td>Kenya</td>
<td>320</td>
<td>14</td>
<td>89</td>
<td>4.4</td>
</tr>
<tr>
<td>Lesotho</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Malawi</td>
<td>33</td>
<td>3</td>
<td>7</td>
<td>9.1</td>
</tr>
<tr>
<td>Mozambique</td>
<td>46</td>
<td>0</td>
<td>9</td>
<td>0.0</td>
</tr>
<tr>
<td>Mauritius</td>
<td>331</td>
<td>9</td>
<td>266</td>
<td>2.7</td>
</tr>
<tr>
<td>Rwanda</td>
<td>154</td>
<td>0</td>
<td>87</td>
<td>0.0</td>
</tr>
<tr>
<td>South Sudan</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>284</td>
<td>10</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>Uganda</td>
<td>74</td>
<td>0</td>
<td>46</td>
<td>0.0</td>
</tr>
<tr>
<td>Zambia</td>
<td>76</td>
<td>3</td>
<td>37</td>
<td>3.9</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>28</td>
<td>4</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1392</strong></td>
<td><strong>45</strong></td>
<td><strong>566</strong></td>
<td><strong>3.2</strong></td>
</tr>
</tbody>
</table>

Comment

Reported cases and deaths: The Kingdom of Lesotho has not reported any case. Eswatini, Malawi, Mozambique, South Sudan, and Zimbabwe had each reported less than 70 cases by 23rd April. Uganda and Zambia had reported 74 and 76 cases respectively. Rwanda (154); Tanzania (284); Kenya (320) and Mauritius (331) had reported the highest number of confirmed cases. Mauritius had a steep increase in reported cases from around 20th March (total 328) but started plateauing from 10th April. Maybe the epi curve will start sloping—this needs more time to observe. The number of reported cases in Kenya is still on the rise with 14 deaths recorded (CFR4.9%). Tanzania recorded a low number of cases till about 9th April when the curve made a steep rise. Overall, Tanzania had reported 254 cases and 10 deaths (CFR 3.9%). Rwanda's curve is more flat but still on the rise: the total number of reported cases is 147 with no death.

The reported cases at the beginning of the pandemic in the region were all imported. The region then transitioned into community transmission in many countries. COVID-19 is a new infection whose testing and control measures were not in place until it struck. Because of challenges in capability for testing, and the fact that many infected people show no symptoms and some with mild symptoms could have missed, it is possible for the reported cases to have been undercounted, as the situation is reported
elsewhere globally. Case Fatality Rate (CFR) - the proportion of cases of a specified condition that are fatal due to that condition within a specified time, is a proxy measure for the severity and prognosis of the condition under review compounded with the effectiveness of the response measures implemented. The CFR seem to be high in some cases within this period, but there could be biases due to time lag of testing and under-testing of all possible cases. It also changes with changing capabilities of the response. We shall observe it over time to have a more realistic level by the end of the epidemics. However, the overall current CFR of 3.6% is lower than the global one at 6.8% (as of 21st April).

Conclusion: The burden due to COVID-19 is increasing among the countries supported by ECSA-HC. The organization will keep a close look at the progression of the pandemic as it also supports the countries to strengthen their response initiatives. The increasing numbers of cases reported and the high CFR demand a sustained effort both at country and regional levels. The interventions ECSA-HC has initiated to support countries strengthen their response efforts is a joint effort with countries and should be continued and if possible, expanded in scope, within available resources.

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7 WHO African Region: External Situation Report 8