The East Central and Southern Africa Health Community (ECSA-HC) has continued to monitor the status of COVID-19 in Burundi, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Mauritius, Rwanda, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe, since March 13th 2020. This is the fifth report on the burden of COVID-19 in those countries. Data were collected mainly from online public domains, with clarification from in-country focal contacts. This report covers the period of 5th June to 12th July 2020.

**Trend**

Kenya reported the highest number of cumulative confirmed cases of COVID-19 in the region (10105), followed by Malawi (2364), South Sudan (2021), Zambia (1895), Rwanda (1337). Mauritius, reported only 3 more cases, with a total of 355. Lesotho reported 233 cases. The trend of cases reported is shown in Fig 1. The daily update on COVID-19 burden in the countries whose data are compiled here is available at: https://datawrapper.dwcdn.net/NttBg/4/.

Fig 1a: Reported Confirmed cases of COVID-19 in ESA Countries including Kenya, 13th March-12th July 2020

Kenya with 10105 reported confirmed cases is an outlier among the rest
The number of reported cases of confirmed COVID-19 increased by 212% in the region, compared to reports of the preceding period up to 4th June 2020. Lesotho reported an increase of 5725% (from 4 to 233 cases); Malawi 502% (from 293 to 2364 cases); Eswatini 350% (from 38 to 1351 cases); Zimbabwe 315% (from 237 to 985). Kenya reported the highest number of new cases at 10105 having increased by 332% from 2340. Table 1 shows reported cases per country.
Table 1: Reported confirmed cases and deaths due to COVID-19 in ESA Countries, March 13th-May 20th 2020

<table>
<thead>
<tr>
<th>Country</th>
<th>Reported cases on 12th July Total (New*)</th>
<th>% Increase in cases</th>
<th>Reported cumulative deaths</th>
<th>Recoveries</th>
<th>CFR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>191(128)</td>
<td>203</td>
<td>1</td>
<td>118</td>
<td>0.5%</td>
</tr>
<tr>
<td>Eswatini</td>
<td>1351(1051)</td>
<td>350</td>
<td>20</td>
<td>668</td>
<td>1.5%</td>
</tr>
<tr>
<td>Kenya</td>
<td>10105 (7,765)</td>
<td>332</td>
<td>185</td>
<td>2881</td>
<td>1.8%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>233 (229)</td>
<td>5725</td>
<td>2</td>
<td>32</td>
<td>0.9%</td>
</tr>
<tr>
<td>Malawi</td>
<td>2364 (1971)</td>
<td>502</td>
<td>38</td>
<td>557</td>
<td>1.6%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>1157 (805)</td>
<td>229</td>
<td>9</td>
<td>364</td>
<td>0.8%</td>
</tr>
<tr>
<td>Mauritius</td>
<td>342 (7)</td>
<td>2</td>
<td>10</td>
<td>330</td>
<td>2.9%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>1337 (927)</td>
<td>263</td>
<td>4</td>
<td>684</td>
<td>0.3%</td>
</tr>
<tr>
<td>South Sudan</td>
<td>2021(1027)</td>
<td>103</td>
<td>38</td>
<td>333</td>
<td>1.9%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>509 (Not reported)</td>
<td>0</td>
<td>21</td>
<td>183</td>
<td>4.1%</td>
</tr>
<tr>
<td>Uganda</td>
<td>1023 (501)</td>
<td>96</td>
<td>0</td>
<td>970</td>
<td>0.0%</td>
</tr>
<tr>
<td>Zambia</td>
<td>1895 (806)</td>
<td>74</td>
<td>42</td>
<td>1412</td>
<td>2.2%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>985 (746)</td>
<td>315</td>
<td>18</td>
<td>328</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23513 (15965)</strong></td>
<td><strong>212</strong></td>
<td><strong>388</strong></td>
<td><strong>8860</strong></td>
<td><strong>1.7%</strong></td>
</tr>
</tbody>
</table>

Deaths

Overall, 103% (146) more COVID-19 related deaths occurred between 5th June and 12 July 2020, than in the previous reporting period (21st May and 4th June 2020). No deaths have been reported in Uganda by this period. No new deaths were reported in Burundi and Mauritius. The highest increase in deaths was reported in Malawi where 34 (850%) more deaths were reported. Eswatini reported 20 more deaths from 3 (567% increase); Kenya reported 107 (137%) more deaths; and South Sudan reported 28 (280%) more deaths. The cumulative case fatality ratio was 1.7% (Table 1).

Recovery

Out of a 23513 confirmed cases that were cumulatively reported, 388 (1.7%) died and 8860 (37.7%) were declared as recovered. About 62% are therefore still under follow-up and care. Mauritius, reported 7 new imported cases and nearly all identified surviving identified cases (322) have recovered. The pandemic in Mauritius is fairly well controlled.
COVID-19 laboratory testing

To establish a valid statement of the burden of COVID-19, countries need to have capabilities to attain a high coverage of laboratory testing. Because of limited capacity and access to testing, laboratory testing is very low in the region. The highest performer is Mauritius with 152,188 tests per million of population (compare Denmark 222,834). Eswatini with 15129 and Rwanda (15028) are next; Zimbabwe has recorded 6446 tests, Uganda 5081 and Kenya 4191 tests per million. The lowest number of tests has been in Burundi with 563 tests per million people (Fig 3).
**Progress of the Pandemic in Mauritius**

In Mauritius, the number of cases rapidly rose to over 300 between March and April 2020. The government imposed control measures early enough, and the result has been a very well controlled epidemic. Government initiated screening of arriving international travellers in January 22nd even before any case had been reported; quarantines at airport started on Feb 28th, persistent media campaign to raise awareness on how to prevent transmission of the disease was implemented early; feedback from government was frank and systematic; lockdown orderly imposed,; a total ‘sanitary curfew’ was instituted and observed.
**ECSA-HC Support**

ECSA-HC has continued to support countries mitigate effects of COVID-19. Due to the prevailing restrictions of travel, much has been provided through online discussions and support. Consultation with countries on their needs continues.

**Interventions**

1. ECSA-HC has continued to hold webinars for health workers in all ECSA-HC countries and beyond. Topics discussed include: clinical management of COVID-19; COVID-19 diagnostics—present and future possibilities; infection prevention and control in the context of COVID-19; expansion of diagnostics in the African region; biosafety and biosecurity in the context of COVID-19. IHR (2005) and preparation and deployment of rapid response teams follow.
2. Other training has included: surveillance at Points of Entry, contact tracing, case management and laboratory diagnosis of COVID-19, in Lesotho, Malawi and Zambia
3. In Kenya, the organization has supported capacity building for sub-national rapid response teams and expanding testing capacities—seven of the EAPHLN-supported laboratories (Wajir, Machakos, Malindi, Busia, Marsabit, Kitale and Moi Teaching and Referral Hospital, MTRH) are now testing centers for their catchment regions for COVID-19.
4. ECSA-HC is collaborating with the East African Community and the Ministries of Health in East Africa to implement a coordinated regional approach to COVID-19 response, with emphasis on Points of Entry.
5. ECSA-HC is coordinating the procurement and distribution of laboratory reagents and supplies with funding from Skoll’s Foundation and CORDS.
6. ECSA-HC coordinated a meeting between national and cross-border teams of Zambia and Tanzania for the Chirundu, Siavonga (Tanzania) and Hurungwe, Kariba (Zimbabwe) districts. Like in East Africa, participants raised concern about cross-border transmission of COVID-19, and the need to harmonize screening, testing and contact tracing protocols, and improve cross-border sharing of relevant information. Truck drivers and commercial sex workers were noted to be especially a risky population. The team agreed a COVID-19 Medical certificate that will facilitate efficient movement of truck drivers carrying essential goods across the border. Contact tracing teams with membership from either side of the border were formulated for real time communication.
7. ECSA-HC is also collaborating with AUDA-NEPAD and other regional and international organizations like ILO to develop Occupational Health and Safety (OHS) guidelines in the context of COVID-19, especially addressing the question of “safe return to work”. Weekly online webinars on OHS in the context of COVID-19 have been conducted where all sectors including mining, retail, education, agriculture, transport have participated.
8. As a member of the Africa CDC COVID-19 surveillance Technical Working Group, ECSA-HC has continued to participate in weekly meetings and contributed to the development of several guidance documents that include the Expansion of Community Health Workers under the Africa Union Partnership for Accelerated COVID-19 Testing (PACT) Initiative, Resumption of Air Transport Operations in African Countries: Public Health Key Considerations
Comment

Since the last report on 4th June, the numbers of reported cases of confirmed Covid-19 in the region have more than trebled. This could be because of expanding coverage of testing or/and accelerating infection rates. Because the testing is still so low, and the deaths have as well more than doubled, the picture is of an accelerating pandemic in the ECSA-HC region. Country differences are however noted. Mauritius had a fast rise in cases, and quickly brought them down. The mortality also remained low. Lesotho reported no single case until May, but cases have increased to 239 in about a month; Zambia had a fast increase in cases but has started to show some slowing. Kenya has had a very steep increase in the last month. At 10105 cases, it has the highest reported numbers of confirmed COVID-19 cases in the region. The implication of these observations is that more effort to control the pandemic in the region is needed. The pandemic is taking different forms in the observed countries. Lesotho just reported the first case. Kenya and Zambia had an accelerated increase in cases. Mauritius and Tanzania had stagnated in numbers reported. The overall number of deaths increased too, but two countries (Lesotho and Uganda) had not reported a COVID-19 related death yet.

The burden of cases under care or follow up is still high—at 62% of identified cases. For their management, these recovering cases demand resources, including human resource for health, medical supplies, physical facilities (for care, isolation and quarantine) and laboratories.

The progress of the pandemic in the region was slow in the initial stages, but is now steadily accelerating. Only Mauritius seems to have flattened its epi curve, and started a steady drop. Kenya, Zambia, Malawi and South Sudan have shown sharp acceleration. It is not known what shape the individual country curves may take. This depends on the interventions adopted and the external global factors prevailing. At this point in time, the World Health Organization has classified the pandemic in Mauritius as “Sporadic cases”; in Zimbabwe, Uganda, Lesotho and Burundi as “clusters of cases”; the rest of countries as “Community transmission”.

The transmission of COVID-19 is driven by virus biological factors, human behavior and economics. Given the rising burden of disease, more effort in the region is needed to control the pandemic. More resources for control are needed. Therefore, ECSA-HC approach to collaborate with partners such as US CDC, Africa CDC, CORDS and others, should be stepped up and natured. While this burden is getting higher, the countries need to balance it against the need to open up their economies. Because of the interconnectedness of countries in the region, country containment and response efforts should consider

---

1 No cases: with no confirmed cases; Sporadic cases: with one or more cases, imported or locally detected; Clusters of cases: experiencing cases, clustered in time, geographic location and/or by common exposures; Community transmission: experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to: large numbers of cases not linkable to transmission chains; large numbers of cases from sentinel lab surveillance; and/or multiple unrelated clusters in several areas of the country/territory/area; Pending: transmission classification has not been reported to WHO.
the regional needs. Joint regional response initiatives like the regionally agreed cross-border screening of truck drivers that both EAC and SADC are developing need to be supported.

All countries continue to face challenges in securing COVID-19 supplies like testing kits, Personal Protective Equipment, ventilators and others due to pressure on the global supply chains. In response, the Africa Union launched the Africa Medical Supplies Platform, a single online marketplace to enable the supply of COVID-19-related critical medical equipment. African Union Member States are able to purchase certified medical equipment such as diagnostic kits, PPE and clinical management devices with increased cost effectiveness and transparency through the platform (https://amsp.africa/)

As more and more countries begin to ease restrictions under the pressure to save both the health of the population and their economies, development and implementation of safe return to work policies and guidelines is critical to avoid spiking of cases. Industry specific guidelines to cover travel, mining, education, informal and informal sector are needed to address general and sector specific needs. ECSA-HC and AUDA-NEPAD and other international partners have been working on these sector specific guidelines which will be available soon.

Conclusion

The number of reported confirmed cases of COVID-19 in the region is increasing, in spite of the context of under-reporting. The burden of cases under care is getting bigger. At the same time, the governments wish to open up economies to take care of individual and national economic survival. Targeted and special populations interventions need to be developed in the context of modified social distancing mechanisms. Health Partners are needed to offer the needed support with diagnostics, care of recovering cases, contact tracing and surveillance across countries, taking note of the fluid movement of people across borders. The region adopting collaborative efforts would therefore be cost-efficient. ECSA-HC is in pole position to offer this coordination, as exemplified by the non-costly webinar sessions that have been held since March, and found to be very helpful to the consumers.

Editorial Team

Willy Were, Christopher Minja, Amani Paschal, Martin Matu, Walter Odochi

Contacts

East Central and Southern Africa Health Community
157 Olorien, Njiro Road,
P.O. Box 1009
Arusha, Tanzania.
Email: covid19@ecsahc.org / werew@ecsahc.org