PANDA

PANDEMICS - DATA & ANALYTICS

Mail panda@pandata.org
Web pandata.org
Facebook @pandata19
Twitter @pandata19

ARTICLES

COVID-19, the vaccine, and the betrayal of sub-Saharan Africa

David Bell
Muhammad Usman Khan

DECEMBER 2020

A strange shift in health priorities

In December 2020, it is likely that child mortality increased across much of sub-Saharan Africa. This is an unavoidable consequence of interrupted healthcare access and growing malnutrition in a year that has seen a singular focus on Covid-19. While the WHO reassured children in developed countries of Santa's immunity to the virus such that he was allowed into the airspace to distribute gifts, increasing numbers of children in Africa have become orphaned due to the reversal of gains in the management of HIV/AIDs and tuberculosis (REF TGF).

The 'Global Health Community' that previously prioritized these diseases and the other big child killer, malaria, implicitly considers these avoidable deaths an acceptable cost in the attempt to reduce transmission of SARS-COV-2 - the coronavirus with a predicted infection fatality rate of about 1 in 2000 for the 99% of sub-Saharan people below 70 years of age, and far lower for the 50% of youngsters under the age of 19. Additional factors such as the climate, low obesity and a low incidence of other comorbidities, may also have left most Africans effectively protected from Covid-19. While numbers are likely to be under-reported as remote cases are missed, testing is extensive, indicating that these trends are real. In spite of this, influential organizations in global health are calling for restrictive measures to continue until a vaccine is available and all are vaccinated - sometime in the coming years. The comparison of low COVID-19 mortality and rising

mortality from other causes in these countries is stark, indicating that we will kill many, mainly children, for the benefit of a relative few.

As wealthy countries and private philanthropy plan to divert large donations to this cause and a global alliance under the COVAX umbrella is gearing up to lead it, there is an urgent need to examine whether this is an undeniable global health good, of benefit to the people for whom it is intended, and whether it really has anything to do with equity.

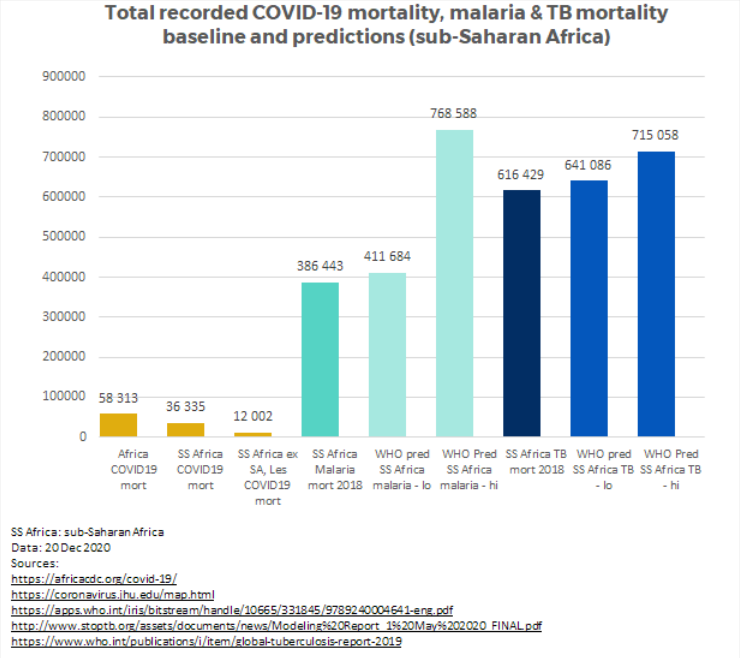
The virus and the response

The virus, SARS-COV-2, was initially feared to be highly lethal and capable of killing up to 1 in 20 infected people. The initial mortality rates for northern Italy's elderly looked frightening when transferred to the entire population of the African continent. Governments, corralled by the WHO, narrowed their focus on dealing with what was initially presented as an existential threat to medical infrastructure, globally. As more data poured in, it became clear that the challenge the virus presented, although serious, was not the global catastrophe previously feared. But seemingly undeterred by emerging data - the infection fatality rate is now estimated at 0.23% and far lower for those under 65 years of age - global health institutions and governments continue to allocate hefty resources and a blinkered focus on the pandemic with undiminished urgency.

However, half of the billion-plus people in sub-Saharan Africa are under 19 years of age, and we have known for most of 2020 that most SARS-COV-2 infections in children are barely symptomatic. Regardless, a climate of fear was sustained, regarding a looming 'catastrophe' for African countries. While European nations locked down their populations to emulate the highly restrictive measures employed in China, the WHO advocated for similar measures across Africa. This ran contrary to its own prior evidence-based pandemic guidance and with seemingly little regard for the high vulnerabilities to pre-existing epidemics (such as malaria, TB and HIV/AIDS), as well as the limited capacity of these populations to absorb income loss.

The catastrophe currently unfolding in Africa is not due to the coronavirus. Despite months of community spread in crowded cities, recorded COVID-19 mortality was under 70,000 across the entire continent by 1 January 2021. If we exclude the Mediterranean countries and South Africa with their differing demography and co-morbidities, this drops to just 13,031 in over a billion people – that is one in every 80,000 people. As the figure shows, COVID-19 would likely have gone unnoticed in this population if we had not been testing for it. Yet, we are where we are – the apparently new virus has dominated the policies of donors and international organizations on an unprecedented scale, and while African countries may be easing internally, the focus externally remains on COVID-19, and now on a vaccine whose roll-out in these populations would defy all previous public health norms.

This catastrophe goes far beyond health alone. A generation of children's schooling has been interrupted and lower income and rural children will likely never recover. A generation of girls and young women have been pushed back into the trap of early marriage and poverty. Economies are devastated and basic human rights and democratic norms, globally, are under renewed threat.



Global Health's loss of innocence

How was the rhetoric of the Global Health community regarding equality proven so hollow? How were philosophies regarding health care, women's independence, girls' education and child nutrition pushed aside so easily, with so little discussion about the current and proposed approaches? Without any serious pushback from its staff, the World Health Organization and wealthy philanthropic foundations advocated for policies that impoverish, restrict and reduce healthcare access, abandoning previous recommendations advising against such measures. In a new form of post-colonial oppression, the rich world, via Zoom meetings, has advocated policies that are inevitably leading to further impoverishment of the world's poor. As collateral damage grows, COVID-19 barely registers in the mortality statistics of most sub-Saharan countries. Talk of 'building back better' will not comfort orphaned children, nor a mother whose children starved to death, nor an adolescent woman forced into an early village marriage. It cannot resolve the issue of millions of hungry children denied a proper education. As these numbers grow larger, the 'building back' can no longer be 'better' – at least not for a generation or two.

With the WHO increasingly dependent on private funding, perhaps the seeds of the African COVID-19 disaster had long been sown. The WHO was conceived to be an instrument for the countries comprising its Assembly – the peoples of the world. It was to be supported financially by these countries, according to their means. The rise of large private philanthropies, who arguably dominate the current global public health agenda, has undoubtedly brought great benefits in terms of almost unlimited funding, new ideas and enthusiasm, though this may not always be fully aligned with local priorities. Not least of all in the field of vaccines where both development and deployment have been greatly accelerated, to the benefit of millions. However, it has also moved the center of gravity of policy-making away from countries (peoples) via the WHO and UN, towards wealthy foundations in high income countries. They are both rivals and also influential funders (of the WHO, The Global Fund, Gavi, and other institutions). Public discomfort at

this status quo may extend beyond the purely philosophical realm if control and prioritization of healthcare moves from the countries concerned (in reality the WHO deals mostly with low- and middle-income countries) into private, and potentially even corporate interests. The WHO's traditional firewalls against corporate conflict of interest have not been impervious to corporate philanthropy, or the philanthropy of those with parallel corporate interests. This does not suggest intentional bias, but it does open the way for a divergence between what the populations of recipient countries require, and what external interests consider to be most needed. To quote CS Lewis, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive."

One vaccine to save us all

Vaccines have transformed public health, especially in African countries where reductions in the childhood scourges of measles, tetanus, meningitis, pneumococcal pneumonia, polio and other disease burdens can largely be attributed to the disease and transmission-modifying immunity they provide. In recent months, the world has been focused to an unprecedented extent on the development and trials of vaccines for SARS-CoV-2, in the hope that they will release people from the broad restrictions that many now face and return a sense of normality. While initial trial data only addresses a reduction in symptoms (personal protection), and these form the primary endpoints of the trials, the aim of eliminating the virus through vaccination, an outcome only previously achieved with smallpox, is broadly discussed. A poorly considered campaign

towards mass immunization is being promoted, despite the current lack of evidence of a transmission-blocking effect, and more importantly, despite the very low impact of COVID-19 on younger people, and thus on the vast majority of Africans. This raises a new paradigm for global health – vaccinating children not for their own health, but in order to protect a small cohort of elderly citizens – who, through acquired immunity, are expected to become less vulnerable to the disease as time passes. This situation is unusual, made all the more so by the fact that the financial and local staff resources needed to support this massive single vaccination programme will reduce the availability of vaccines and other healthcare interventions against other and worse diseases that these same children face. Foreign aid from increasingly cash-strapped donor countries is being sought for the COVAX mechanism in the name of global equity, while local health staff, logistics and expertise will be drawn from other pressing areas. This will be an enormous undertaking never previously attempted in such a short timescale and across all age-groups.

Another unprecedented claim made to justify this approach is the idea that the populations of sub-Saharan Africa require vaccination in order to reduce the risks for those living elsewhere.

If we believe the SARS-CoV-2 virus can and should be eradicated globally, but we recognize that diverting resources for this programme will cost lives, then we need to acknowledge that the children who are no longer benefiting from other health interventions, are dying for the benefit of mostly elderly and chronically-sick people in far wealthier nations who wish to reduce their own Covid-19 risk. It may not be 'wrong' if the benefit to Africans can be shown to outweigh the costs. But clearly, if this is not demonstrated, then the equity argument behind COVAX and the universal COVID-19 vaccination programme becomes unsustainable. It is therefore patently wrong, and a travesty of public health policy.

Restoring progress and decency

We, as the Global Health Community, need to pause, question, and think for ourselves. By any normal measure, we are catastrophically failing the people we were entrusted to serve. The current approach appears to be causing net harm, and African health is at risk of being crushed under a model designed by and for others. COVID-19 is a chance to re-set, but not through the deaths of children and the impoverishment of tens of millions. Fixing this will take humility and self-awareness. To build a better future, we first need to avoid doing more harm. Let's hope, collectively, we have the courage and moral decency to undo the mess we have created. Then we must support the peoples of these countries in continuing the broad improvements in health care upon which they, with admirable support from both public and private sectors, had previously embarked.

ABOUT THE AUTHORS

Dr David Bell is a clinical and public health physician with a PhD in population health. Previously, he was Director of the Global Health Technologies at Intellectual Ventures Global Good Fund in the USA, Programme Head for Malaria and Acute Febrile Disease at FIND in Geneva and coordinating malaria diagnostics strategy with the World Health Organization.

Muhammad Usman Khan is a health policy analyst. Usman has consulted and worked in advisory roles for multiple governments and NGOs.

REFERENCES

1. https://www.theglobalfund.org/media/9819/covid19_mitigatingimpact_report_en.pdf
2. https://www.oxfam.org/en/press-releases/12000-people-day-could-die-covid-19-linked-hunger-end-year-potentially-more-disease
3. https://www.who.int/bulletin/online_first/BLT.20.265892.pdf
4. https://population.un.org/wpp/Download/Standard/Population/
5. https://www.frontiersin.org/articles/10.3389/fpubh.2020.604339/full
6. https://www.afro.who.int/covid-19-africa-response-areas

7. https://ww2.gatesfoundation.org/ideas/articles/coronavirus-vaccine-strategy-bill-gates/?fbclid=IwAR1kc5C2ibT_vIMUpYGCjOyg1ECqWHCchJReMPA2-zhNIExHVPN42TGZ8Kw
8. https://www.who.int/initiatives/act-accelerator/covax
9. https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm
10. https://www.who.int/bulletin/online_first/BLT.20.265892.pdf
11. https://population.un.org/wpp/Download/Standard/Population/
12. https://www.nature.com/articles/s41586-020-2918-0
13. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7158570/
14. https://www.weforum.org/agenda/2020/04/africa-covid-19-time-bomb-defuse/
15. https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf
16. https://africacdc.org/covid-19/
17. https://news.un.org/en/story/2020/08/1069442
18. https://www.savethechildren.org/us/about-us/media-and-news/2020-press-releases/covid19-half-a-million-more-girls-risk-of-child-marriage?cid=Social_Network:Twitter:Health_Coronavirus:Scus_Lp_Post1:100120
19. https://www.worldbank.org/en/news/press-release/2020/06/08/covid-19-to-plunge-global-economy-into-worst-recession-since-world-war-ii
20. https://www.who.int/social_determinants/tools/multimedia/alma_ata/en/
21. https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf
22. https://www.fda.gov/media/144416/download
23. https://ww2.gatesfoundation.org/ideas/articles/coronavirus-vaccine-strategy-bill-gates/?fbclid=IwAR1kc5C2ibT_vIMUpYGCjOyg1ECqWHCchJReMPA2-zhNIExHVPN42TGZ8Kw
24. https://www.who.int/initiatives/act-accelerator/covax
25. https://ww2.gatesfoundation.org/ideas/articles/coronavirus-vaccine-strategy-bill-gates/?fbclid=IwAR1kc5C2ibT_vIMUpYGCjOyg1ECqWHCchJReMPA2-zhNIExHVPN42TGZ8Kw

Cover photo by Doug Linstedt on Unsplash