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Insights From Africa's Covid-19 Response: The Africa CDC

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Summary

The Africa Centres for Disease Control and Prevention (Africa CDC) is a relatively young (founded in January 2017) and ambitious organisation that has carved out a leading role in public-health advocacy and advisory across the African continent. It has achieved this in spite of its small size and mandate to support countries of generally low public-health capacity amid supply shortages. It should now be strengthened.

Background to the Africa CDC

The Ebola outbreak between 2013 and 2016 that precipitated the foundation of the Africa CDCACDC, and the Covid-19 pandemic to which it is now responding, differ considerably. The former centred on three neighbouring countries and a disease we have been building a progressive understanding of since 1976, with a much higher case fatality rate but reasonably well-established clinical practices. By contrast, the current pandemic is significantly larger in scale, encompassing all African countries and at the time of writing has more than 50 times as many confirmed cases than seen in the Ebola crisis, though only about three times as many known deaths. At the time Covid-19 started to spread beyond China, the virus was a largely unknown quantity – and our understanding of its routes of transmission, effect on human health and means of effective treatment has evolved in real time as we have sought to suppress it. If Ebola helped to expose the need for an African public-health agency, then Covid-19 is the ultimate test for the one the continent has built.

But the Africa CDC was not designed for a health crisis of this scale involving a novel, non-tropical virus. At just four years old, the Africa CDC is still establishing itself. It is relatively small organisation, employing fewer than 100 staff who are mainly concentrated in Addis Ababa. It receives comparatively modest funding from a parent organisation, the African Union, with its own budgetary challenges, and is heavily donor-reliant. As an imperfect comparison, the European Centre for Disease Prevention and Control on which it was modelled is an organisation that has been maturing for 16 years, has 269 members of staff and a €60.5 million budget in 2020 – and all to serve a community with 28 fewer Member States, each with higher-capacity national public-health bodies than can be found in Africa, and about 620 million fewer people. [1] Similarly, the WHO Regional Office for Africa budgeted $95 million for strengthening organisational capacity and $74 million on health emergency preparedness activities in 2020-21 alone, not to mention the significant programmatic spending in its country offices and its 2,500 staff members distributed across the continent. [2] It was clear that the Africa CDC would not be able to provide bespoke, simultaneous and day-to-day support to the national public-health institutes that are responding to the virus in the same way the WHO country offices can. Nonetheless, as an Africa-grown institution associated with the continent's most inclusive international organisation, and considered nimble and ambitious with one of Africa's preeminent virologists at its helm, the Africa CDC was perfectly positioned to provide continental leadership. But because, like the WHO, the Africa CDC is not a national public-health agency, it must operate by consent and through the willing engagement of Member States. Though it can run its own central research programmes, it must advise and seek to coordinate – while being sensitive to national contexts and political imperatives – in order to have impact.

Organisational memory of emergency responses to successive, localised outbreaks of Ebola, cholera, chikungunya virus and Rift Valley fever over the last four years has helped to establish a structure and battle rhythm that could be adapted and applied to Covid-19. Nonetheless, this was the first time that the African Union's public-health-emergency protocol had been activated. This unchartered territory, combined with broader African Union policies that were not designed with periods of rapid response in mind, may have delayed or constrained the realisation of some of the Africa CDC's ambitions during the crisis. The Africa CDC has benefited from additional financial support since the pandemic started – including from the Rockefeller Foundation and the Bill & Melinda Gates Foundation, the Eastern and Southern African Trade and Development Bank, the governments of Japan and the United Kingdom, and the European Union. But a significant proportion of this and other money raised through the African Union Covid-19 Response Fund is likely to go directly to Member States or be spent on tangible assets, rather than the Africa CDC's organisational development. [3] It also pales in comparison to the funds given directly to governments through loans and grants for health responses – the spending of which the Africa CDC may be able to influence but cannot prescribe.

Mobilising to Respond to Covid-19

Considering this context, the Africa CDC's work on Covid-19 has been impressive. The Africa CDC has been described in The Lancet as "leading the efforts to control Covid-19" on the continent alongside the WHO Regional Office for Africa, and its director Dr John N. Nkengasong – himself a former Head of Virology at the WHO – has been recognised by the Bill & Melinda Gates Foundation as "a central voice for Africa's scientific community" and for his "significant commitment" to the pandemic response. [4]

The Africa CDC was notable in both the proactive speed of its initial mobilisation and the breadth and depth of its ongoing response. It established its Emergency Operations Centre and Incident Management Systems for Covid-19 in late January, three weeks before the first case was confirmed on the continent, and has published a summary briefing on the outbreak every week since. It ran trainings for representatives of 16 African countries on use of PCR for detecting Covid-19 infection the week before the first case, at which point most countries did not yet have equipment or laboratory capacity. [5] By the first week of February, the Africa CDC had convened African national public-health institutes virtually and started to develop a shared understanding of the virus as a basis for pan-African cooperation. In the spirit of collaboration and to encourage active participation and ownership, a task force was established and leadership and oversight responsibilities for different areas of the Africa CDC's response were allocated to Member State representatives. Within days of the first case being confirmed on 25 February, all African Union health ministers had met in Addis Ababa and the "Africa Joint Continental Strategy for Covid-19 Outbreak" had been published, identifying broad objectives for the Africa CDC's response and principles for collaborating with other political and public-health bodies. The Africa CDC's headline intention was to "promote" and "support evidence-based public health practice", specifically in surveillance of the spread and prognosis of the disease, access to diagnostic and protective equipment and quality-assured laboratory capacity, effective virus control measures and health-system preparedness, and risk communication.

Considering its own limited human resources, effectively managed partnerships have been essential for productivity and scale of impact. WHO representatives were engaged in the Africa CDC's work from the start of the pandemic and capacity-building exercises and supply-chain support for 15 countries had started before the continent's first confirmed case. [6]The Africa CDC has published a number of capacity-building materials for Member States in multiple languages and a range of formats, co-created by the Africa CDC and collaborating organisations on the African continent and beyond. The Africa CDC has also curated and cascaded resources from other bodies through its own channels, most notably the African Society for Laboratory Medicine and the WHO.

Countries everywhere have scrambled to procure the protective, diagnostic and therapeutic equipment needed to cope with the pandemic. Countries in the Global North – with the necessary funds and favourable credit – have taken purchasing risks and, in some cases, stockpiled. In sub-Saharan Africa, where access to funds is more constrained, government procurement systems are less developed, and the size of orders is likely often smaller and distribution channels are weaker, the challenge of procurement has been especially pronounced – from availability and affordability to logistics and quality assurance.

Efforts have been made to address these challenges. UN agencies have mobilised their supply-chain expertise and distribution networks. The private sector and philanthropists have made monetary and in-kind donations, chief among them Jack Ma and the Alibaba Group. [7] African flag carriers have used their cargo divisions to ferry supplies, despite many facing huge financial challenges in their passenger divisions. [8] The Tony Blair Institute for Global Change has supported the repurposing of domestic manufacturing to shorten supply chains. [9] Global North governments too have contributed to the African Union Covid-19 Response Fund and bilaterally to individual African nations. [10] Nonetheless, what the Africa CDC describes as "acute shortages" of supplies have been seen across the continent, in the richest and the poorest countries – from South Africa and Nigeria, to Malawi and the Democratic Republic of the Congo. [11] Shortage of protective equipment in particular has been a driving force behind health-worker strikes across the continent and throughout the pandemic. These supply challenges endanger the health and wellbeing of everyone – doctors, patients and the public at large.

In this context, the Africa Medical Supplies Platform (AMSP) was established in June under the leadership of African Union Special Envoy Strive Masiyiwa and with the participation of the Africa CDC. The aim was to pool demand to maximise purchasing power of African countries, ensure price competitiveness; promote transparency in procurement and fair distribution according to need, simplify payment processes, reduce logistical delays and ensure quality supplies. The platform originated in the Pharmaceutical Initiative launched in 2019 by the United Nations Economic Commission for Africa, in partnership with the Intergovernmental Authority on Development, WHO and other stakeholders. [12] Anchored in the African Continental Free Trade Agreement, the platform is rooted in a model of continental collaboration, fair pricing and sustainable financing. It is a clear example of pre-existing initiatives being repurposed to address new challenges – in this case from maternal and child health to pandemic response. The model rests on a number of public- and private-sector partnerships, and by engaging early with a key lending partner, the African Export-Import Bank (Afreximbank), the AMSP was able to secure an initial $100 million in financing to enable Member States to procure through the platform and negotiate shipping rates with logistics companies. Unlike the WHO Covid-19 Partners Platform where payment for supplies must be made upfront, Afreximbank has made funds available in the form of pre-approved overdraft limits for each government. Nonetheless, data on the number of transactions on the platform, the size of loans offered to individual governments, and the

quantity of different categories of product purchased is still unknown; it is therefore not possible at this time to quantify how significantly the platform has contributed to plugging supply gaps on the continent. The platform encourages local consumption by highlighting African manufacturers on its homepage and alerting customers to locally produced alternatives when supplies from foreign manufacturers are placed in their baskets – but as of today, only ten out of about 400 supplies listed for sale on the platform are made by African companies. While the initiative has huge potential, more buy-in is needed.

Facilitating Testing

Shortages of testing kits and the equipment to analyse samples has caused particular concern. [13] Surveillance-driven strategies – including rigorous testing and tracing – have been key in countries that have brought their outbreaks under control. South Korea was the first country globally to adopt open public testing, including for asymptomatic people, and has had a test-positivity rate of less than 1 per cent for the majority of the duration of the pandemic; effective testing and rapid isolation of cases has been credited for the rapid pace with which the curve of new infections was bent downwards through the first ten days of March. [14] But testing policies in Africa have been consistently the most conservative in the world. Most African countries have tested only symptomatic people from specific groups throughout the duration of the pandemic, reflecting a widespread shortage in testing reagents and strained lab capacity. For most countries, the test-positivity rate has been consistently in excess of the 5 per cent threshold, above which the WHO says the epidemic is out of control, and has widely and often been in excess of 10 per cent. [15]

This is despite the Africa CDC's efforts to advocate for increased testing and to facilitate it by brokering and providing resources. Very rapidly, it supported national governments to establish new laboratories compliant with key international regulations, and to significantly augment testing capacity by providing expertise, equipment and assays. With poor coordination on supply chains in the Global North, the Africa CDC worked to advance Africa's continental procurement interests. To support improved decision-making about resource allocation, it is working in partnership with the African Society for Laboratory Medicine to map the availability, capacity and biosafety level of laboratories throughout Africa. [16] Since April, the Africa CDC has used the slogan "If you don't test, you won't find" and repeatedly stressed the importance of testing in its briefings. It committed to distributing 1 million test kits by the end of that month, as part of the wider Partnership to Accelerate Covid-19 Testing (PACT), which had directly enabled 3.4 million tests to be administered by the end of June. [17]

But by the director's own admission, the reagents supplied and tests conducted as a result of the Africa CDC's support are "far below … need". [18] According to its own figures, by the start of August, only ten countries accounted for 80 per cent of tests conducted on the continent, as was the case two months before. [19] The number of tests performed per 1,000 people per day across the continent has remained consistently low. [20] But the Africa CDC must be credited for aiming to achieve what was realistic given the scale of the outbreak, the resource-intensity of PCR testing and the significant, structural constraints. The approach helped countries that had been priced out the market to access kits more reliably. Critically, the Africa CDC is rightly directing attention to alternatives that can help to close the testing gap, particularly rapid diagnostics including antigen tests. It has built a strategic partnership with

the Foundation for Innovation New Diagnostics to obtain equitable supply of tests for Africa and extend its ability to prepare countries for their rollout. [21] Readiness to adopt these new technologies will be key to overcoming the challenges the continent has faced so far.

The Future for the Africa CDC

Throughout the pandemic, the Africa CDC has hit above its organisational weight. Within a busy international policy architecture, it has cemented its legitimacy and identified ways to add value. The African Union system and donors should recognise this and support the Africa CDC in the next stage of its development, as it grows its Regional Collaborating Centres located across the continent and enters into its next strategy period from 2022 to 2026. Member States should work to ensure their own national public-health institutes engage consistently and benefit fully from the Africa CDC's offer – and the global community should support it through funding and partnership. The Africa CDC must be at the forefront of supporting Member States to cope with both the long-term fallout of this pandemic – including disrupted vaccination campaigns for other communicable diseases and the need to roll out a Covid-19 vaccine – as well as any future outbreaks. As lifestyles in Africa change and the burden of non-communicable diseases continues to increase, the Africa CDC must be ready to respond to new challenges and an ever-more complex public-health picture.

Footnotes

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