HEALTH stakeholders have warned that the COVID-19 third wave is imminent given the prevailing situation with damning evidence that the country is ill-prepared.

With the Easter holidays only a week away, the situation is bound to worsen and statistics will rise.

Government has said it will upscale surveillance and other control measures to curb a possible spike in COVID-19 transmissions during the Easter holidays.

Addressing a post-Cabinet media briefing, Information minister Monica Mutsvangwa said there was a likelihood of increased human traffic which posed a huge risk of increased transmission of the disease.

“In that regard, the Ministry of Health and Child Care is strengthening surveillance, case management and risk communication and community engagement in anticipation of the Easter holidays. Special attention will be accorded to ports of entry and exit,” she said.

Mpilo Central Hospital acting chief executive officer Solwayo Ngwenya has said the third wave is loading following the relaxation of lockdown measures.

“IT will be like adding fuel to a raging fire. Zupco buses will be overcrowded. That’s a recipe for disaster.”

He said he had observed that the informal traders, who are now back on the streets, were not observing regulations.

“I saw many not practising social distancing and some were not wearing their masks properly. That’s a bad brew and a third wave is loading. We are brewing it,” Ngwenya said, adding that a new variant circulating in Zimbabwe would only make transmission more rapid.

“With winter approaching, this will escalate. Vaccines do not stop infection, they just boost your immunity,” he said.

Ngwenya said before global herd immunity is achieved, people would still get new variants as they travel, hence the need for new vaccines.

“The virus is going to find you and infect people. Some will die. So you are better off being poor and hungry and alive than being buried six feet under,” he said.

Meanwhile, health experts have expressed concern over the country’s state of preparedness in the event that a third wave of COVID-19 hits the country, amid reports that most health institutions still do not have adequate infrastructure to cater for such an emergency.

Recently, President Emmerson Mnangagwa pleaded with citizens to embrace the government-funded vaccination programme to enable the country to achieve at least 60% herd immunity and contain the spread of the highly infectious respiratory disease.

Zimbabwe Senior Hospital Doctors Association president Shingai Nyaguse told NewsDay there was need for more hospital beds and piped oxygen in preparation for any eventualities.

“While a lot of work was done in terms of infrastructure upgrades to facilities, several projects remain incomplete, like Khuzilieni Hospital and several others countrywide,” Nyaguse said.

“Here are still many facilities requiring to be fitted with piped oxygen which is the main treatment for COVID-19. Supply of adequate drugs and sundries remain a challenge in the public sector,” Nyaguse added.

Zimbabwe Nurses Association president Enock Dongo said: “Nothing much has been done by government. There is need for proper facilities and more to deal with the third wave. Health institutions are not fully equipped and there is need to increase the number of COVID-19 facilities. We do not see any activity pointing to government’s commitment in dealing with the pandemic. We cannot solely rely on vaccination. In South Africa, 3,000 health workers were inoculated, but they tested positive again to the virus within 28 days.”

Medical and Dental Private Practitioners of Zimbabwe Association president Johannes Marisa weighed in, saying the country’s state of preparedness is unresolved. So overall, there is still some work to be done if we are to improve outcomes. Zimbabwe currently has the highest case fatality rate in Sadc.”
What is COVID-19 vaccine efficacy?

In an incredible scientific feat, COVID-19 vaccines have been developed within less than a year after the virus was first detected.

Several vaccines that have become available have shown different levels of efficacy. So what is vaccine efficacy? Leading paediatrician Lee Hampton explains.

What is vaccine efficacy and why is it important?

Vaccine efficacy measures a vaccine’s protection against a disease/pathogen in a vaccine trial.

If a vaccine has, for example, 70% efficacy, it means a person vaccinated in a clinical trial is around two-thirds less likely to develop the disease than someone in the trial who didn’t get the vaccine.

When you give a vaccine outside a clinical trial, we then refer to vaccine “effectiveness”.

Compared with efficacy, effectiveness takes into account all the complexities of the real world, outside of a controlled clinical trial setting.

So far several COVID-19 vaccines seem to be highly effective in real-world settings.

However, we still need to assess the full consequences for each vaccine’s effectiveness against newly identified variants that cause COVID-19.

For example, the AstraZeneca vaccine seems to have lower efficacy than the Pfizer vaccine at preventing mild to moderate disease, but has proven very useful in preventing severe disease, with nearly 100% efficacy against at least some variants of the virus that cause COVID-19.

There is no single standard vaccine efficacy threshold set for COVID-19 vaccines. Any decision to use a vaccine or drug always involves weighing the benefits against the risks.

In some vaccines, like the malaria vaccine, we are willing to accept relatively low efficacy because the problem is so severe, and the need for some protection is so great.

The COVID-19 vaccines all have different efficacies. Which one should I take?

There has been a lot of focus on using COVID-19 vaccines to protect against symptomatic disease.

But what we really care about how these vaccines protect against severe disease, hospitalisation and deaths.

The data so far shows that all these vaccines are better at protecting against severe disease, hospitalisation and death than against symptomatic disease.

Vaccines protect against severe disease, hospitalisation and deaths.

What is COVID-19 vaccine efficacy?

Vaccine efficacy measures a vaccine’s protection against a disease/pathogen in a vaccine trial.

The data so far shows that all these vaccines are better at protecting against severe disease, hospitalisation and death than against symptomatic disease.

This is because preventing a virus from getting to the point of severe disease is easier than preventing all symptoms.

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Community Working Group on Health executive director Itai Rusike decried the high level of complacency by the public, especially in public transport which may lead to soaring numbers in terms of COVID-19 infections.

“We really need to have COVID-19 literacy programmes and involve the people so that communities become part of the COVID-19 literacy programmes. Very few people are still properly wearing face masks, there is very poor adherence. The issue of social distancing is also being poorly practised. The third wave may be a harsher variant compared to previous ones, meaning that a lot of people may die if we don’t put adequate mechanisms in place,” Rusike said.

The 50% efficacy threshold set for COVID-19 vaccines is because COVID-19 was deemed such a severe disease, that if a vaccine is only 50% effective, it’s still worth using.

Fortunately, the emerging data on COVID-19 vaccines suggests that the vaccines are very safe and highly effective, at least against some of the variants.

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For example, the AstraZeneca vaccine seems to have lower efficacy than the Pfizer vaccine at preventing mild to moderate disease, but has proven very useful in preventing severe disease, with nearly 100% efficacy against at least some variants of the virus that cause COVID-19.

Given the very real risks from COVID-19, the high degree of safety we’ve seen so far from COVID-19 vaccines, and the evidence that COVID-19 vaccines provide protection, especially against severe disease, hospitalisation, and death, I would personally take any WHO-recommended COVID-19 vaccine offered to me, and I have advised my family, including my parents who are in their late 70s, to do the same.

— WHO

Studies that report lower efficacy against infection might be more rigorous in trying to identify if someone was infected or not.

Is there a standard vaccine efficacy threshold and should a lower level be a concern?

While it’s generally thought that preventing infection is the goal of a vaccine, there are other important considerations.

Additional factors include how severe infection is, how long a person is contagious, and whether the disease spreads faster or slower.

Another important difference is the population in the trials. Clinical trials are designed to be very strict and controlled, which is why they can provide such useful data, but it makes it much harder to do direct comparisons between vaccines.

All clinical trials provide rigorous data, but it makes much harder to do direct comparisons between vaccines.

For this you’d need a head-to-head trial, with the same protocol for all the vaccines, delivered and tracked in the same way.

With COVID-19 vaccines, different clinical trials have looked at how well vaccines protect against symptomatic and asymptomatic infection as well as how well they protect against severe disease, hospitalisation and death.

While it’s generally thought that protection from a given dose of vaccine fully kicks in about two weeks after that dose is given, some trials are designed to assess how much protection the vaccine provides starting immediately after that dose. Others will assess efficacy after two weeks following vaccination.

Another important difference is the way trials might measure outcomes. To detect COVID-19 infection, for example, participants might just have to self-report symptoms, or they might be given regularly scheduled blood tests for signs of the virus.

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AROUND 1 200 pupils in secondary schools and tertiary institutions recently received free COVID-19 tests and certification offered by Parirenyatwa Group of Hospitals in partnership with Strive Masiyiwa’s Higher Life Foundation.

The gesture came as a huge relief for most parents who were paying hefty amounts ranging between US$50 and US$70 for the polymerase chain reaction (PCR) and between US$15 to US$30 for the rapid tests after most schools demanded COVID-19 certificates as a prerequisite for admission into class.

The voluntary free of charge tests kicked off last week and wound up on March 22, 2021 at Parirenyatwa Group of Hospitals.

Students coming for testing were asked to bring their institution’s identity card or letter from the principal of their school confirming their status.

Some schools demanded the rapid tests while some opted for the more reliable PCR which costs between US$50 and US$70 depending on the medical facility.

“We understand the reasoning behind but imagine someone with three children. How are you supposed to come up with more than US$100 on top of the fees and uniforms,” said one parent.

In some instances, however, there was confusion on the rapid tests as many parents were not aware that there were two types, the antigen and the antibody.

Some schools were turning away pupils with rapid antibody certificates and demanding antigen tests.

“Being a Sunday we struggled to get the preferred antigen. It is too stressful for us. Schools should explain in detail these differences because we are not all medical people,” said a mother of three students who had to fork out an extra US$90 for a re-test.

The parents also blamed certain health facilities for not explaining the differences.

“Why were they doing these antibody tests if they are useless?” asked another aggrieved parent.

According to the Centre for Disease Control, a rapid antigen test detects viral proteins.

The rapid antigen test reveals patients at the peak of the infection when the body has the highest concentration of these proteins.

The disadvantage is that they are not as sensitive (accurate) as the standard RT-PCR tests used to accurately identify those infected.

When using them, a significant percentage of those infected pass the test as a false negative. In a few days, these people will spread the virus among others, thinking they are healthy.

So if one is being tested with the rapid antigen test, they are not guaranteed to be uninfected at the time of taking the test.

An antibody test on the other hand measures antibodies to the SARS-CoV-2 virus in the bodies of people who have already had COVID-19 or are successfully recovering from the disease.

Antibodies are not present at the onset of the disease so again an infected person may get a false negative result.
COVID-19 ‘infodemic’ a major drawback

COVID-19 conspiracies and rampant misinformation in Zimbabwe have adversely impacted the effectiveness of containment strategies put in place by government, including the mass vaccination programme.

Since the outbreak of the respiratory disease last year, various social media platforms have been inundated with fake news ranging from overnight cures, to discouraging people from taking the vaccine.

Chief coordinator for the COVID-19 task force, Agnes Mahomva, recently said fake news and misinformation, coupled with fear, have become a huge problem for the country.

“We have to do away with the panic when we see numbers shooting up. Fake news and misinformation is our biggest challenge that we have to deal with,” she said.

Speaking during a health summit convened by Alpha Media Holdings through one of its publications, The Standard, Mahomva said this impeded preventative programmes aimed at halting further spread of the disease.

“Let us not miss the ball again. Let us hold on and continue with the strategies including the vaccine,” she said.

Mahomva said the second wave had been managed well, but any complacency would reverse the gains and throw the country’s health-care system into further disarray.

Explaining the choice of vaccines for Zimbabwe, Mahomva assured the nation that careful consideration had been backed with scientific evidence.

Responding to queries why Zimbabwe had chosen Sinopharm ahead of other vaccines, she said the inactivated vaccine had been compared with other vaccines and fared favourably.

She said they had taken a bit of time before settling on Sinopharm simply because they were analysing the data which was approved by the Medicines Control Authority of Zimbabwe.

“We are satisfied and happy with it (Sinopharm),” she said.

Inactivated vaccines use a pathogen that has been modified so that it cannot replicate to stimulate the immune system.

They are safe and suitable for those with a compromised immune system. However, booster doses may be necessary.

Mahomva dispelled myths that the vaccines would cause sterility and urged people to take it than be exposed to the virus.

“While globally fake news is everywhere, Zimbabwe has taken it to another level. We create jokes about misinformation,” she said.

Speaking on the fake news crisis, Zimbabwe Association of Doctors for Human Rights secretary Norman Matara said mistrust of government by the people was fuelling the misinformation.

He said results from a study had shown that half of the participants did not think the vaccine would work, while a similarly large percentage doubted if the vaccine had been tested given the accelerated development of the vaccines.

“But the vaccine was highly comparable in terms of efficacy and safety, but people have trust issues with the government,” Matara said.

Globally, misinformation about COVID-19 has been said to fundamentally distort people’s risk perception of the virus.

The World Health Organisation has even warned of an on-going “infodemic” or an over-abundance of information — especially misinformation — during an epidemic.