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Different SARS-CoV-2 variants, same prevention strategies

Letter to the Editor

On the 24th of November 2021, the National Institute for Communicable Diseases (NICD) of South Africa reported the detection of a new COVID-19 variant of concern (VOC), named B.1.1.529, from a specimen collected on the 9th of November 2021 [1]. Early evidence on this variant suggests that it has a very unusual array of mutations, increased antibody resistance and is possibly more transmissible. Some countries have responded by issuing travel restrictions from South Africa and other countries in the region. Several studies are already underway to understand the variant's properties, such as whether it can evade immune responses triggered by vaccines and the severity of disease in infected individuals. The announcement of the detection of VOCs brings anxiety, both to the public and to healthcare providers, as the worst scenarios are anticipated. Similar to when the delta variant was detected, concerns of increased transmissibility, changing disease patterns, vaccine effectiveness, and the effectiveness of the pre-existing infection prevention and control measures arises.

From the onset of the COVID-19 pandemic, and before the availability of vaccines, measures such as physical distancing, wearing of medical facemasks, hand hygiene (washing hands with liquid soap or using alcohol-based hand sanitisers), improving ventilation of indoor spaces and avoiding crowded spaces and unnecessary gatherings were the cruxes of infection prevention and control. These measures were in addition to key public health interventions, such as isolating of confirmed cases and quarantining of close contacts. Throughout the pandemic, from the alpha variant to the beta variant and lastly the delta variant, these interventions have remained very important. With fears of reduced vaccine effectiveness against the delta variant, the Centers for Disease Control and Prevention (CDC) recommended that the public maintain these prevention measures. The World Health Organisation (WHO) has also continued to encourage these strategies in the face of vaccine inequity, with many low-to-middle income countries still far from attaining their herd immunity thresholds. Viruses mutate all the time and, whilst the clinical and epidemiological characteristics may change, the control measures remain the same.

A few weeks before the B.1.1.529 variant was announced, South Africa had asked Johnson & Johnson and Pfizer to delay delivery of COVID-19 vaccines because the country was overstocked, with reports of serious vaccine hesitancy among the population [2]. As of the 26th of November 2021, 35% of the South African adult population were fully vaccinated [3], which is half the government's year-end target. There is need to rejuvenate the vaccination momentum in South Africa and other countries in sub-Saharan Africa to propel them towards their herd immunity thresholds and realise population-wide benefits. This requires renewed vigour and innovative strategies to fight vaccine hesitancy in these countries. Vaccination is one of the most critical public health interventions to reduce the morbidity and mortality associated with

severe SARS-CoV-2 infection, and convincing evidence of this has been provided in various studies, with countries that are advanced with vaccination programmes now reporting markedly reduced COVID-19 deaths despite high incident cases. However, it is important to note that vaccination alone is insufficient to contain the outbreak and adherence to the standard infection prevention and control measures remains key.

A study conducted among 19,933 adults living in South Africa revealed that over three-quarters of respondents self-reported violating stay home orders [4]. Similarly, poor face mask use and symptomatic individuals not self-isolating has been reported in South Africa [5]. Pandemic fatigue, a phenomenon where the population get tired of hearing about the pandemic and abiding to control measures, which has been described widely in other settings, is a likely driver of the violations of staying home orders, mask wearing and physical distancing. In Zimbabwe, pandemic fatigue, leading to human complacency, was perceived as a key driver of the third COVID-19 wave that occurred between June and August 2020.

The public must be reminded of the need to guard against complacency and remain vigilant, especially as we get into the festive season, which is associated with increased human mobility, including in-country and international travels. To this end, various public health stakeholders involved in risk-communication and community engagement need to devise innovative ways of communicating with the public regarding the emergence of VOCs, the need to stick to standard infection prevention and control protocols, and that currently available vaccines are safe and effective. The public also needs to be alerted to the fact that SARS-CoV-2 is likely to persist as an important respiratory pathogen in the future, VOCs will continue to emerge, prevention will remain our key strategy to limit the morbidity and associated mortality, and socioeconomic disruptions associated with harsh epidemic waves will continue. The use of all the different forms of communication available, including diverse social media to dispel falsehoods, myths and misconceptions and fight against vaccine hesitancy ahead of conspiracy theorists and antivaxxers, is important. Lastly, there is a strong need to emphasise that, despite the continued emergence of new VOCs, the same control strategies still work.

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