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Trouble in Vaccine Land: The Wiliness of South Africa's Coronavirus Variant

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It began as a shudder through the scientific and public health establishments. A new variant of the novel coronavirus SARS-CoV-2 had been found, mutating in South African climes, potentially outwitting human responses to it. Vaccines such as Oxford-AstraZeneca's would have to be brushed up. Rollouts would have to be reconsidered.

The South African variant has been given a few designations: 501Y.V2 or B.1.351. Within it lies a mutation –N501Y – which suggests a greater degree of contagiousness. Another, E484k, might bypass the human immune system, thereby blunting the effectiveness of the vaccines.

A study on the effectiveness of the Pfizer vaccine against N501Y and E484k mutations found that the vaccine did still work, but with less efficacy. The authors of the study treaded carefully, making it clear that the study had made assumptions about levels of neutralisation. The biological functions of N501Y and other mutations also remained "to be defined for viral replication, pathogenesis, and/or transmission in animal models."

The concern for the Oxford-AstraZeneca vaccine is graver, given that it was deemed the great hope for developing countries, with lower pricing and less demanding conditions for storage. Preliminary, and yet to be peer-reviewed research of some 2,000 individuals, has found the vaccine to have less impressive protections (under 25%) against mild-to-moderate illness caused by the 501Y.V2 variant.

The same cannot be said about protecting against severe COVID-19, an open point given that those recruited in the study were generally healthy, young and sporting only mild symptoms. None required hospitalisation. Such qualifications were seized uponby World Health Organization's Director-General, Tedros Adhanom Ghebreyesus. "Given the limited sample size and the younger, healthier profile of the participants it is important to determine whether or not the vaccine remains effective in preventing more severe illness."

Despite this not entirely gloomy picture, politicians in South Africa have been bitten by fear. As the country most affected on the African continent, doses of the Oxford-AstraZeneca vaccine are being traded in favour of Johnson & Johnson shots. The latter vaccine has also been shown in trials to be less effective in combating the mild aspect of 501.V2 (57%)

though does a much better job of combating instances of severe disease (85%).

The announcement of this policy shift came from the Health Minister Zweli Mkhize on February 10: “Given the outcome of the efficacy studies [the government] will continue with the planned phase one vaccination using the Johnson & Johnson vaccines instead of the AstraZeneca vaccine.”

This would have delighted the J&J crew, given that the one-shot vaccine has only been approved for use in studies in South Africa and has yet to be officially authorised for general use in any country. Applications for emergency use from South Africa’s regulatory authority and the US Food and Drug Administration have been made. Not to worry, claimed Mkhize: the vaccine had been tested on 44,000 people so far; safety for intending recipients was assured.

The health minister was also keen to give the impression of business. “Our scientists are continuing to evaluate other [vaccine] candidates and we are simultaneously engaging manufacturers. We are in advanced stages of evaluating and engaging the manufacturers of the Sputnik V candidate. Engagements with Sinopharm continue, with an offer already made by China for vaccines which are being considered.”

The move has not convinced certain health practitioners. Sipho Dinabantu of Chris Hani Baragwanath Hospital is worried that “that trust we had in the government to do a proper vaccination program” has evaporated. “We were given assurances that it was ready to go but now it has been put on hold. It makes me wonder a lot about the Johnson & Johnson vaccine, which has yet to be approved.”

The risk of waste is a serious one. A million Oxford-AstraZeneca vaccines have been procured from the Serum Institute of India. These are due to expire at the end of April. Shabir Madhi of the University of Witwatersrand, the lead investigator of the South African trials of that vaccine, finds it rather daft that these would not be used, despite acknowledging its weaknesses. “It doesn’t make any sense to have 1 million doses of vaccine available to us known to be safe and to not start distributing it at least for high-risk groups.” The country’s elderly and those with comorbidities could receive those shots.

Mkhize hopes that these might be sold or swapped depending on what the Ministerial Advisory Committee suggests. Countries were already making inquiries. But there are concerns that expired vaccines might also find their way into the program. We only have Mkhize’s assurance that the vaccines had not expired, and would not be administered if they had.

Confidence in public health authorities has again received a bruising, though the South African government has its defenders. Professor Willem Hanekom, director of the Africa Health Institute, was all praise at the decision to embrace the J&J option. “We’ve never been in such a situation. Every day things change, and we need to adapt to these changes.” The trend of treating whole populations as guinea pigs in a grand public health experiment continues.

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