These are the (β, α, δ) days of our lives

A year ago, I wrote a piece entitled 'COVID-19: The greatest global critical care challenge of our time' in this journal. As we surge into the third wave across the country at the time of writing, as we reflect on all that has happened in the intervening period, and as we brace ourselves for the challenging upcoming period, those words still ring true. The massive challenge of COVID-19 still remains.

Nowhere is the challenge of COVID-19 greater than on our streets and our healthcare facilities. According to the expanded definition of unemployment, the national unemployment rate reached an all-time high of 43.2% in quarter 1 of 2021.[1] The paltry ZAR350 COVID-19 grant is a distant memory, the unemployment insurance fund relief is long gone, the general public is suffering from a severe case of pandemic fatigue, and countless hamstrung businesses have only just begun to limp along after the last year's devastation – only to be faced with a terrifying third wave. The situation is equally distressing on the health front. Facilities stretched to the limit are forced to triage patients while a crucial fire-ravaged centre still waits to be fully reopened, demoralising allegations of corruption continue plaguing the health sector and high-profile individuals, and healthcare workers have been pushed way beyond their limits to the point of severe burnout, and now they are facing a terrifying third wave.

The accompanying paper in this journal describing the organisational response of critical care services to the COVID-19 pandemic at Groote Schuur Hospital makes for interesting reading, and highlights the numerous challenges faced.[2] Over a 13-month period spanning the first two waves, 461 patients with COVID-19 were admitted to their intensive care unit (ICU) with only 35% surviving to hospital discharge. This high mortality among intubated ICU patients has been a particular source of much despondency among critical care personnel at many centres. Teamwork, flexibility, and good communication were emphasised by the Cape Town group, and these need to be key elements in any unit wishing to respond effectively. The identification of a shortage of nurses as the main limit on ICU expansion emphasises the crucial role of these vital angels of care as the backbone of all ICUs. It is vital that we appreciate, honour, and treasure them.

COVID-19 continues impacting on the functioning of the Critical Care Society of Southern Africa (CCSSA) by presenting many challenges. Again, we had to decide to cancel our annual national conference planned for July 2021, a decision borne out by the throes of the third wave. Members have thus missed the premier educational and social event on our society's calendar for 2 years. Virtual platform national refresher meetings will continue to act as replacements but are a far cry from our vibrant face-to-face meetings of times gone by. Many struggle with this loss of contact.

Much else has happened in the intervening period. CCSSA can be proud of its collaborative effort with the African Perioperative Research Group (APORG) to initiate and successfully complete the African COVID-19 Critical Care Outcome Study (ACCCOS), recently published in the *Lancet*.[3] The study, attempting to address the notable African COVID-19 data gap, demonstrated a mortality rate of 48.2% for patients with suspected or confirmed COVID-19 that needed critical care. This higher mortality in comparison with the global mortality (31.5%) indicates an excess mortality of 11 - 23 deaths per 100 patients. Resource challenges were clear, with only one in two patients referred to ICUs being admitted, and poor access to life-saving interventions such as dialysis, pulse oximetry and oxygen.

Two other important issues emanated from the ACCCOS study. First, despite being under-resourced overall, Africa may be surprisingly subject to underutilisation of its limited resources. It is estimated that at least 40% of medical equipment in Africa remains out of service, and that 70 - 90% of equipment donated across Africa has never been operationalised.[4] This needs to be addressed urgently. Second, research challenges in Africa remain numerous and significant, ranging from large prohibitive clinical loads, difficulty in fulfilling ethics and regulatory requirements, limited dedicated research personnel and restricted funding opportunities. The enthusiasm of all personnel involved in ACCCOS across 64 hospitals in 10 countries should serve as an impetus for establishing a sustainable critical care network across the continent.

Debates around COVID-19 vaccination-related issues continue to rage across our land and across the world. From the challenges of acquisition of vaccines to the delayed rollout of the vaccination programme, from vaccine hesitancy to vaccine opposition, from questions around degree of protection to poor uptake in many sectors, our nation is charged by differences in opinion. The unequal distribution across societies and across countries around the world has been stark. At the 74th World Health Assembly, World Health Organization head Dr Tedros Ghebreyesus launched the summit by lambasting the 'scandalous inequity' in the global COVID-19 vaccine rollout.[5] Ten countries accounted for 75% of all doses administered. Dr Tedros implored world leaders to ensure that at least 10% of the population of every country is vaccinated by September, and 30% by the end of 2021. In South Africa (SA), as of 3 July 2021, only 3 305 965 vaccinations had been administered across the country in total, of which 479 773 were part of the Sisonke programme.[6] When evaluating these numbers, one has to bear in mind that the majority of the people have only received one of two doses of the vaccine. Overall, the proportion of the SA population that has been vaccinated to date compares very unfavourably with many less-resourced countries across Africa. We have much to do in this respect.

Multiple genetic variants of SARS-CoV-2 detected through genomic surveillance programmes have been emerging and circulating around the world throughout the COVID-19 pandemic. These variants have one or more mutations that differentiate them from other variants in circulation. Some of these include the beta (β), alpha (α) and delta (δ) variants, which are variants of concern as they may be associated with increased transmissibility, severe disease and a reduction in neutralisation by antibodies generated during previous infection or vaccination. The recent devastation across the Indian subcontinent as a result of infections due to the δ variant served as an ominous harbinger for what may be in store for SA and Africa, a reality that is fast developing with a calamitous surge in infections in Gauteng province at the time of writing.

Some 16 months ago, COVID-19 swiftly moved from the backpages of our news to the forefront of our existence, savagely sweeping across the world, turning it upside down, and leaving us scrambling for our survival. As we approach 4 million deaths globally, COVID-19 has established itself as the latest event that emphasises, exploits and exacerbates inequalities that have a negative impact on various health and socioeconomic outcomes. We need to safeguard against such inequalities. Additionally, we need to reflect on our losses, remembering and honouring the many

friends, colleagues, acquaintances and loved ones who are no more. We need to salute the many healthcare personnel who continue to dedicate themselves to serving on the frontlines. We need to remain steadfast but patient in our approach to restoring the rhythm of our lives. We need to diligently apply the fundamentals of our public health response that have not changed. Above all, we need to remember that this is also a time for hope for things to get better.

P D Gopalan, MB ChB, FCA (SA) Crit Care, PhD;
OrcID 0000-0002-3816-1171
Discipline of Anaesthesiology and Critical Care, School of Clinical Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa
President: CCSSA
gopalan@ukzn.ac.za

South Afr J Crit Care 2021:37(2):41-43. https://doi.org/10.7196/SAJCC.2021.v37i2.507

1. Statistics South Africa (Stats SA). Quarterly labour force survey. Pretoria: Stats SA, 2021. http://www.statssa.gov.za (accessed 3 July 2021).
2. Michell W, Joubert I, Peters S, Fredericks D, Miller M, Piercy J, et al. The organisational response of a hospital critical care service to the COVID-19 pandemic of in a resource-poor setting: The Groote Schuur Hospital experience. South Afr J Crit Care 2021:37(2):63-69. https://doi.org/10.7196/SAJCC.2021.v37i2.503
3. Biccard BM, Gopalan PD, Miller M, et al. Patient care and clinical outcomes for patients with COVID-19 infection admitted to African high-care or intensive care units (ACCCOS): A multicentre, prospective, observational cohort study. Lancet 2021;397(10288):1885-1894. https://doi:10.1016/S0140-6736(21)00441-4
4. Worm A, Griffith-Jones L, Namahungu T, Chimphepo H, Soroheye P. The (improved) status of medical equipment in sub-Saharan Africa healthcare technology management. Geneva: WHO, 2017. https://www.who.int/medical_devices/global_forum/3rd_gfmd/statusmedicalequipmentSub_SaharaAfrica.pdf?ua=1 (accessed 1 July 2021).
5. Ciara Linnane. WHO head slams scandalous inequity in COVID vaccines with 10 countries accounting for 75% of doses administered. Market Watch, 24 May 2021. https://www.marketwatch.com/story/who-head-slams-scandalous-inequity-in-covid-vaccines-with-10-countries-accounting-for-75-of-doses-administered-11621866783 (accessed 3 July 2021).
6. National Department of Health (NDoH). COVID-19 online resource and news portal. Pretoria; NDoH, 2021. https://sacoronavirus.co.za/latest-vaccine-statistics/ (accessed 3 July 2021).