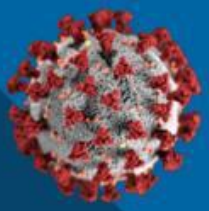

EFZ COVID 19

Response Document

Evangelical Fellowship of Zimbabwe

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SECTION 1
THE CREATION AND MANDATE OF COVID-19 RESPONSE TASKFORCE

1.1 A Summary Overview of Context and Mandate

In December 2019, the Corona Virus(Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) often also referred to as COVID-19 pandemic broke out from Wuhan, China, and rapidly spread throughout the world causing a worldwide health crisis. This crisis resulted in economic and social disruption and ensuing lockdown efforts were made to stop or combat the spread of the Corona Virus now commonly known as COVID-19. Several measures and protocols to combat this pandemic were adopted and currently include the following; the Wearing of Masks, Sanitization, Social Distancing, Restriction in movement or Lockdown, and Contact Tracing. Except for Singapore, New Zealand, and Taiwan, these measures did not result in the manifest and sustained reduction of cases of infections and we are now experiencing a second wave of COVID-19 mutants and variants.

To date (as of 8 February 2021) an estimated 97 million cases of infection with 2.3 million deaths have been reported worldwide, with the highest rise in cases reported in the United States, UK, South Africa, and recently in Zimbabwe. The second wave of the Corona Virus has had a marked impact in countries like the United Kingdom, South Africa, and recently Zimbabwe. Zimbabwe in the month of January has seen a rise in cases and deaths, with several prominent persons succumbing to COVID-19 (4 Cabinet Ministers amongst others). Church services and Pastoral Ministry have been severely affected by gathering restrictions while supermarkets, open markets, restaurants, and food outlets, and public transporters who often do not exhibit the same level of diligent compliance as the Churches, are allowed to operate under less stringent conditions.

The outbreak of the Corona Virus in 2019 and its presence in Zimbabwe added to the existing and ongoing challenges and crisis that Zimbabwe was and is facing. These challenges include the following;

1) Economic Challenges
2) Institutional Capacity Challenges
3) Health Care delivery Challenges
4) Corruption
5) Political disunity, fragmentations, and contestations
6) Social challenges caused by 95% unemployment and the 2019 drought followed by cyclone devastations.
7) International Sanctions and isolation.

The economic and social degradation has had a serious impact on the livelihoods of ordinary people and the quality of their lives. It was observed right from the onset

that the national pre-conditions that exist in Zimbabwe would make it difficult for ordinary people to observe or be compliant with the COVID-19 protocols. This economic and social context made the combating of COVID-19 that much more complex and almost unwinnable under the existing COVID-19 protocols. This was further compounded by the initial lack of up to date information and trends on COVID-19 cases, hot spots, and the uneven handed policies and their implementation regarding public gatherings and other public restrictions.

Within such an environment, we note also the efforts of the Government of Zimbabwe in COVID-19 Response including but not limited to the following: declaring COVID-19 a national disaster; training of health workers on case management; providing risk allowances and personal protective equipment to frontline workers; unveiled a ZWL 18 billion Economic Recovery and Stimulus Package aimed at revitalizing the economy and providing relief to individuals, families, small businesses and industries impacted by the economic slowdown in 2020; reviewed Echange Control Regulations; the announcement of USD$100 million set aside for procurement of vaccines; engaging the International Community for aid and vaccine donations; ensuring adherence to the WHO protocols; setting up national taskforce and experts to assist Government in COVID-19 responses; providing regular data and COVID-19 statistics; establishing and running quarantine facilities, contact tracing among other commendale efforts.

1.2 COVID-19 Vaccines

The search for a vaccine has produced several vaccines from Pfizer (USA), Oxford-Astra Zeneca (UK), Moderna (USA), Johnson & Johnson (USA), Sinovac (China) SinoPharm (China), and Sputnik (Gamaleya) from Russia and drugs from other pharmaceutical entities.Recently Israel and India have indicated that they have developed new vaccinnes as well while new entrants are also appearing in USA and other parts of the world. These vaccines and drugs were produced in record time to mitigate the impact of the COVID-19 on health morbidity and mortality rates as well as stem the economic fall-out. Ordinarily, the creation of a medical solution to a killer-disease would or should be met with relief and jubilation. Regrettably, this has not happened, but instead, the ostensible answer to COVID-19 has raised several questions and inspired a plethora of very strong alternative views and opinions that further make it difficult to decipher truth from fiction or fear.Many of them suggest that the corona virus pandemic is in reality a plandemic. A number of these very strong alternative views and opinions have their bearing or references from the Biblical depictions of the end-times also known as Biblical Eschatology. The unprecedented time it has taken to develop a vaccine, the use of messenger RNA (mRNA) in the development and delivery of some of the vaccines combined with the use of nanotechnology, and the involvement of globalist voices from business, politics, biotechnology, and digital technology has further fueled the uptake of these very strong alternative views, opinions and theories on social media and the Church in particular.

1.3 NEC/NAC Taskforce Proposal

In the face of these complex challenges and developments, many people in the Church are looking to Church leaders for clarity, rationality, spiritual guidance, and direction. It is for this reason that the National Executive Committee (NEC) of the Evangelical Fellowship of Zimbabwe (EFZ) mandated Bishop Muparutsa (EFZ President), to convene a special consultation with the National Advisory Council (NAC) on the 22nd of January 2021 to put together a collective and comprehensive response to the issues outlined above.

The NAC meeting agreed on the creation of a COVID-19 Response Taskforce with the limited mandate of producing a Response Draft Paper in 7 days and a Final Draft in another 7 days. The mandate and tenure of the Taskforce shall then lapse unless renewed by the NAC.

During the NAC meeting, several areas were identified that have a bearing on or are influencing or influenced by the current COVID-19 context outlined above and the issue of vaccines and vaccination rollout.

1) The issue of the nature of the Corona Virus and its medical and scientific development (the ultra-short duration of vaccine discovery and development, the nature of the vaccine, the human trials, the unknown after-effects, etc.).
2) The issue of the economic impact of COVID-19 on Zimbabwe currently and in the foreseeable future.
3) The overall management of COVID-19 response regarding preparedness, policy formulation, institutional and prophylactic management, and the effectiveness of COVID-19 protocols in Zimbabwe.
4) The Management and mitigation of the social impact of COVID-19 including family, marital, and mental health.
5) The management and mitigation of COVID-19 on education and current online schooling.
6) The vibrant and viral Eschatological interpretations deriving from COVID-19.
7) The Review, Engagement and Mitigatory Response to very strong alternative views,opinions and postulations that have gone viral -The very difficult task of separating fact from fiction concerning postulated global political, economic, and satanic conspiracy agendas and New World Order (666).

With these areas in mind, names were proposed of persons who would add value and insight to this Taskforce in the 7 areas identified above. From within its ranks and among identified experts, the NAC identified Dr. G. Shana, Professor M. Mhloyi, Dr. C. Chidoori, Dr. R. Musasiwa, Dr. A. Chisango, and Bishop Dr. C. Nyathi (Special Prayer Mandate), Dr. C. Chimbetete, Dr. P Murima, Dr. G. Kanyenze, and Dr. T. Murisa. A four-member editorial team was set up and was made up of Dr. R. Musasiwa, Dr. C. Chidoori, Dr. P. Murima, and Dr. G. Shana.

1.4 Envisaged Outcomes

The major outcome of this Taskforce is to provide information, knowledge, and objective analysis of the current COVID-19 context to assist Church Leaders and their Churches to do the following:

1) **Make individual and informed decisions** on the scientific, medical, and ethical integrity of the vaccine process, the potential benefits and risks, and the acceptability of the developed vaccines.
2) To contribute to a more sustainable and even-handed policy in the formulation and application of COVID-19 protocols that do not discriminate against the Church and or effectively disrupt or disable the Church and Pastoral Ministry.
3) To contribute to more inclusive and effective ways for the Church to play a part and have its voice heard in national development and transformation of the health delivery system, the economy, social welfare/resilience, and specifically regarding the management and containment of COVID-19 and its impact on the economy and quality of life of our people.

SECTION 2
THE ORIGINS OF THE VIRUS AND ITS CURRENT GLOBAL AND LOCAL STATUS.

2.1 The virus and its origins

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is often also referred to as COVID-19. COVID-19 is a novel coronavirus that was first reported in the province of Wuhan, China in September 2019. It is an airborne strain of the family of Coronavirus not previously identified in humans. The virus has a global mortality rate of 3%, however, Zimbabwe has experienced a slightly higher rate of 3.1%. Its possible origins appear to have been in a wet animal market in Wuhan, China, in early Dec 2019. There was also a strain of the same virus as SARS-CoV-1, which affected 8,000 people in 2002/03. Research has found a 96% DNA match between bat coronavirus and the human one found in a study from February, suggesting that a link to humans is not direct but through an intermediate host. [1]

The Virus itself is made up of 4 proteins and a strand of RNA (a molecule that can store genetic information). One protein is the spike, which gives the crown-like appearance. Two proteins sit in the membrane between the spikes to provide structural integrity. In the membrane, the fourth protein is a scaffold around the genetic material. It generally

[1] The Economics of a Pandemic;the case of COVID-19:London Business school:Paul Surico & Andrea Galeotti

enters through the nose, mouth, or eyes. It then attaches to cells in the respiratory tract producing a protein called ACE2. It fuses with the cell and releases the RNA. The hijacked infected cell will produce proteins based on the “instructions” from the virus’ RNA. Each infected cell can release millions of copies of the virus before dying. It affects the upper respiratory tract (airways from nose to vocal chords), and can spread to the lungs. In serious cases, the immune system can overreact and attack lung cells; in some cases, the infection leads to acute respiratory distress syndrome and possibly death. The virus can also end up in droplets that escape the lungs through coughing or sneezing; this leads to contagion directly to other humans, or indirectly through contaminated surfaces. The average patient infects 1.6 to 2.4 other people. Older patients with existing pre-conditions are disproportionally affected.

2.2 Global and Local Status

Comparisons with other outbreaks:

- 14th century Europe: bubonic plague. 25 million deaths (pop. 100 million).
- 1918-1920 Worldwide Influenza epidemic: 17-100 million deaths
- 1981-current AIDS: >25 million lives + 33 million living with HIV.

Recent smaller outbreaks:

- 2002-04 SARS: 8k cases, 774 deaths.
- 2009 Avian flu: 151k-575k deaths.
- 2014-16 Ebola: >11k deaths. [2]

2.3 The New Wave versus the Global Situation: Dr Austin Jeans in an Op-Ed published on the 21st of January 2021 which was entitled ”***Beating this thing with facts not Fear*”** had this to say of the new wave of infections in Zimbabwe;

> “Zimbabwe has recently experienced a significant increase in COVID-19 cases and related deaths in the past few weeks; almost certainly (yet to be confirmed) a result of the arrival of the so called ‘South African variant’ coronavirus 501.V2. This version of the SARS-CoV-2 virus is far more transmissible, it spreads 50% faster than its predecessor but the disease is not more severe i.e. not more deadly.” Increased recorded deaths are a statistical feature of when the infection rate increases in the population then the exposure of the vulnerable is greater and if hospital facilities become overwhelmed then more deaths will result. Even so, it is important to retain some perspective as this is not Armageddon for Zimbabwe nor the world. I say this for 3 reasons:
>
> i. Zimbabwe COVID-19 hospitalisation stats - the Minister of Health announced recently that of the Covid positive cases only 2-3% of people have needed critical care hospitalisation, 12-13% have been discharged

[2] The Economics of a Pandemic;the case of COVID-19:London Business school:Paul Surico & Andrea Galeotti

within 2-3 days of hospitalisation and the vast majority, over 85%, have simply required self-isolation at home.

ii. Zimbabwe COVID-19 deaths – without diminishing the tragedy of every death, when expressed per million of the population (calculated as total deaths divided by no. of million people in the population) to be comparable to other countries, Zimbabwe ranks very low at 59 deaths per million of the population this is only 4% of the UK Covid deaths per million and 9% of South Africa's Covid deaths per million. Country COVID-19 deaths per million population are as follows;

Country	Number of Covid Deaths per Million Population
Belgium	1,769
Italy	1,385
United Kingdom	1,370
United States of America	1,252
Peru	1,179
Mexico	1,113
Brazil	998
South Africa	651
India	110
Zimbabwe	59

Source: Worldometer

The current COVID-19 death toll in Zimbabwe stands at 1326 which is 0.00006% of our total population and amounts to 2½ days of normal all-cause mortality i.e. how many people sadly die in Zimbabwe daily (which is about 317).

iii. Global COVID-19 statistics: –according to Worldometer data currently stand at >97 million cases and 2 million deaths but still show the detailed situation as: - 99.6% of active cases have only a mild condition versus 0.4% serious/critical - 97% of cases which had an outcome have so far recovered versus 3% died. Effectively nearly 70 million people worldwide who contracted the virus have so far recovered from it, which is perhaps not the general impression one gets from media reporting! A reminder of the USA CDC data on survival rates for COVID-19 which remain validated: Age Group Survival Rate 0 – 19 yrs 99.997% 20 – 49 yrs 99.98% 50 – 69 yrs 99.5% 70 + 94.6%. Furthermore, the 2 million global COVID-19 deaths thus far in a year amount to only 3.6% of the average daily global burden of deaths (approx. 154,000 people die daily worldwide) and we must compare 2 million to the nearly 18 million people who die annually from cardiovascular disease, 10 million from cancer and

6.5 million from other respiratory conditions (2017 IHME Global Burden of Disease).

As of the 8th of February 2021 no further details had been given as to which vaccine will be used in the rollout but a high likelihood was that it would be Sinovac or Sputnik as Zimbabwe has developed closer ties with China and Russia respectively and is not a signatory to COVAX (The WHO/UN convention on combating COVID-19). The efficacy of both Sinovac and Sputnik have been questioned and currently placed at 52%.Other unknowns still surround this particular vaccine not to mention other unknown elements and side effects that are also unknown about all other vaccines as well. WHO has predicted a third and more severe wave that will hit Zimbabwe from May to August this year unless 20% of the population are vaccinated. This may be highly unlikely as vaccine production regardless of the producer still lags behind population needs and producing countries will look first to meeting their needs before exporting any to Africa or the rest of the world.

2.4 **The 5 Levels Of Responses To The Virus.**

The global response to Corona Virus falls into 5 categories.

- **A.** The prevention, reduction, and flattening of infection rates through the now well-known COVID-19 Protocols; masking, sanitization, social distancing, contact tracing, and PPEs.
- **B.** The isolation or quarantining of the infected.
- **C.** The treatment and institutional management of symptomatic cases.
- **D.** The social and economic management and mitigation of the virus.
- **E.** The search and provision of curative and preventative vaccines and drugs.

2.5 The Options Available

Until the recent arrival of the slew of vaccines, therapeutic and prophylactic drugs, there has been no viable and clear solution to the COVID-19 pandemic except the insistence on the stricter application of the 5 responses mentioned above. The COVID-19 protocols while important in fighting the spread of the virus have by and large proved inadequate to reduce the rate of infection even in developed countries and in the South African case has shown that lockdowns, for instance, can exacerbate the viral evolution[3]. The pendulum swings between spikes and lockdowns have also continued to produce both economic and health spasms and shock waves that do not augur well for businesses and livelihoods. The emergence of vaccines and drugs that combat COVID-19 though currently being debated appear to be the only option outside of lockdowns and stricter enforcement of COVID-19 protocols. The arrival of these

[3] https://www.nature.com/articles/s41591-021-01255-3

vaccines and drugs does not spell the end of COVID-19 as their efficacy is not 100% and theoretically does not stop further infection but only reduces symptomatic aggravation. The efficacy of these vaccines against mutations and variants currently indicates reduced impact and this may well mean that the effective control and management of COVID-19 will take time and may still be with us for the foreseeable future as one of the many manageable infectious diseases.

SECTION 3
QUESTIONS AND ANSWERS ABOUT THE VIRUS, VACCINES, AND VACCINATION.

3.1 How do the vaccines work?

RNA, which is closely related to DNA, is present in all living cells. Messenger RNA is a sequence of genetic code that tells cells what proteins to build so that they can function. To produce an RNA vaccine, scientists develop a synthetic version of some of the virus's messenger RNA. When this is injected into the human body, our cells read it as an instruction to start building the proteins, including, in this case, COVID-19's distinctive 'spike' protein. Our bodies then mount an immune response by producing antibodies to fight the virus proteins made by our cells. This prepares our immune system to fight the real virus if we encounter it later. This is different from the way some other vaccines work, where a small part of the virus itself, or the whole virus (weakened or dead), is injected into the body to trigger an immune response. A synthetic version of part of the virus's genetic code is injected. It tells our cells to start building the virus protein, triggering an immune response.

3.2 How is RNA vaccine development different from other vaccine development?

RNA vaccines hold the promise of being faster, cheaper, more adaptable, and easier to mass-produce than other vaccines, because:

- **They can be generated quickly.** RNA vaccines are based on a process of biochemical synthesis that involves fewer components and fewer steps than the more complex traditional methods, like using inactivated live viruses.
- **They are cheaper to develop.** Only a small amount of RNA needs to be delivered into the body's cells, compared to the much larger micrograms of protein that are required for many other vaccines.
- **They are more robust and easier to manufacture at scale**. The same RNA vaccine platform could be used to produce vaccines against different diseases – both known and emerging. A manufacturing plant could, in theory, produce multiple vaccines using the platform, whereas other vaccines, such as MMR (measles, mumps, and rubella) each require a dedicated manufacturing plant.

3.3 Have there been any other RNA vaccines other than those approved for COVID-19?

The Pfizer-BioNTech and Moderna vaccines are the first RNA vaccines ever to be approved for use against any disease. However, researchers have been using the technology for a while, and people have been given RNA vaccines in clinical trials for other diseases, like cancer. A major challenge in the past has been figuring out how to deliver the RNA vaccine into the cell so it survives given that our bodies naturally want to destroy foreign RNA molecules. This innovative use of RNA has only been made possible due to the enormous level of research funding and focus during the pandemic, which has leveraged on breakthroughs in new biotechnologies over the last 20 years. The cutting-edge method could revolutionize vaccine development for future disease outbreaks.

3.4 What are the potential limitations of these novel vaccines?

The announcements are positive news, especially as both vaccines have shown the efficacy of around 95% in phase 3 clinical trials. But there are still many outstanding questions, for example **how long immunity will last, how effective the vaccines will be in different populations, and whether people can still transmit the disease to others if they've been immunized**.

Pfizer-BioNTech has reported high levels of vaccine efficacy in over 65-year-olds – one of the groups most at risk of serious illness. Although many vaccines need to be refrigerated usually around 2 to 8^{o}C; the Pfizer-BioNTech COVID-19 vaccine needs to be stored at least -70^{o}C, which could pose logistical problems for the supply chain, particularly in low and middle-income countries where these unique refrigeration facilities may be limited. The Moderna vaccine can be stored at fridge temperature for 30 days (2 to 8^{o}C) once delivered to healthcare facilities but require -20^{o}C for long-term storage and transportation[4]. We must continue with efforts to ensure fair access to COVID-19 vaccines, for example through the COVID-19 Vaccine Global Access Facility (COVAX). This will be instrumental in ensuring effective vaccines are prioritized for those most in need around the world.

3.5 This is the fastest vaccine developed in human history. Did we short circuit or undermine the safety and efficacy of the vaccine because of the robust development?

The speed in development is a result of;

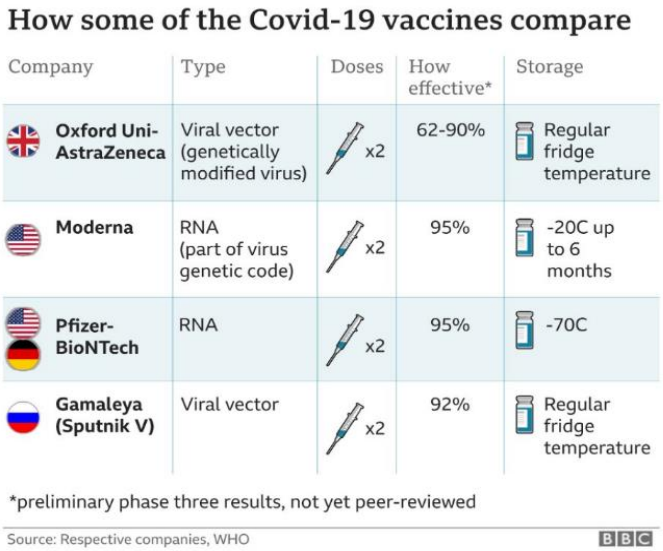
[4] At the time of producing this paper, there was not much publicly available information of other vaccines being developed

a) Several Nobel prize-winning **scientific innovations** over the last 20 years, such as DNA sequencing and genetic engineering. These innovations have enabled the rapid genetic identification of the COVID-19 causing virus, enabling vaccine and drug developers to know the type of arsenal they should create to fight the virus.
b) **The rapid incidence of COVID-19 cases**, also made it possible to speed up the recruitment of eligible patients to the vaccine study. In a normal environment, study completion is a function of recruitment (the ability to find the right number of eligible patients) and the period of investigation. COVID-19 simply made it easy to recruit 30'000 study subjects within 90-days due to a high number of cases.
c) **Years of advanced research.** For years, researchers had been paying attention to related coronaviruses, which cause SARS (severe acute respiratory syndrome) and MERS (Middle East respiratory syndrome), and some had been working on new kinds of vaccine - an effort that has now paid off spectacularly.
d) **There is unprecedented financial support.** A lack of sufficient funding particularly when the technology is new can slow progress. But, given the need to take control of this pandemic, governments across the globe are financially backing the most promising vaccine candidates. Typically, vaccine manufacturers wait to produce large quantities of a vaccine until after it's approved by the FDA. However, the acute need to bring a safe, effective vaccine to the patients, governments funded the manufacturing of several promising vaccines while these candidates were still in clinical trials. This removed the financial risk a vaccine manufacturer would have faced doing this on its own. Being able to manufacture large amounts of a vaccine so early on means it can be distributed shortly after it is approved by regulatory authorities.

3.6 What is special about mRNA vaccines from other vaccines like measles mumps rubella?

Conventional vaccines contain viral proteins or disabled forms of the virus itself, which stimulate the body's immune defenses against infection by a live virus. But the first two COVID-19 vaccines for which efficacy was announced in large-scale (phase III) clinical trials used just a string of mRNA inside a lipid coat. The mRNA encodes a key protein of SARS-CoV-2; once the mRNA gets inside our cells, our bodies produce this protein that acts as the antigen - the foreign molecule that triggers an immune response. The vaccines made by Pfizer and BioNTech and by Moderna both use mRNA that encodes the spike protein, which docks to human cell membranes and allows the coronavirus to invade the cell.

3.7 There are now at least 6 vaccines[5]), what's the difference?



Please note that the source table above does not include the Johnson & Johnson Vaccine which can be stored at room temperature for 6-9 months and only requires one dose. For a comprehensive review of all vaccine candidates, please go to this site, which provides a detailed explanation for non-scientist about all vaccines under investigation, approved, and abandoned (Click Link).

3.8 Do COVID-19 vaccines alter my DNA?

The short answer is No. The mRNA never enters the nucleus of the cell, meaning it does not affect or interact with our DNA. Messenger RNA (mRNA) is found in all living cells. These strands of genetic code act as chemical intermediaries between the DNA in our chromosomes and the cellular machinery that produces the proteins we need to function: mRNA provides the instructions this machinery needs to assemble these proteins. However, mRNA isn't the same as DNA, and it can't combine with our DNA to change our genetic code. It is also relatively fragile and will only hang around inside a cell for about 72 hours, before being degraded. While the new, approved COVID-19 vaccines are the first mRNA vaccines to be licensed by the FDA, the technology has been in use for cancer research since at least 2011.

3.9 Microchips: Can you track me with a chip in the vaccine?

The short answer is no.

[5] *Pfizer-BioNTech; AstraZeneca-University of Oxford; Moderna vaccines; Johnson & Johnson; Russia's Sputnik V Vaccine ; Sinovac Biotech*

3.10 Nanoparticles are used in the COVID-19 vaccines. Should I be concerned and what are they?

The new class of DNA and RNA-based vaccines deliver the genetic sequence (mRNA) of specific viral proteins to the host cells using nanotechnology platforms. For many mRNA-based therapeutics, the vehicles of choice are lipid nanoparticles which offer several key advantages:

a. Promotes the delivery of water-insoluble drugs
b. Enhances the circulation time of drugs *in vivo*
c. Achieves co-delivery of drugs
d. Improves drug utilization efficiency and reduce side effects through targeting antibody modification
e. Protects DNA and mRNA vaccines, overcoming bottlenecks for *in vivo* applications
f. The physicochemical properties of nanomaterials can also be employed directly against viruses

Complexed with lipids, mRNA is more stable and resistant to RNase-mediated degradation and forms self-assembled virus-sized particles that can be administered. Once endocytosed (in the cell), the lipid nanoparticles promote endosomal escape and release their genetic cargo in the cytosol, where the mRNA is translated into antigenic proteins, kick-starting the immune system machinery into producing neutralizing antibodies protecting against the disease encoded.

A current drawback of these formulations is that their long-term storage requires low temperatures, posing logistical hurdles to their potential distribution and administration, for LMICs like Zimbabwe where cold chain transportation might be a hurdle. Nonetheless, these vaccines are a huge achievement for molecular medicine and biotechnology. They also represent a big milestone for nano-medicine, which has struggled to gain mainstream recognition so far due to translation challenges. They are a success for all those scientists who have worked to optimize nano-formulations for the efficient packaging and safe delivery of genetic material. They epitomize some of the ideas behind the concept of drug delivery, and the founding principles of nano-medicine that biocompatible rationally engineered materials can protect drug cargos from degradation and offer control over their biodistribution; intracellular localization, and release.

3.11 There is therefore a lot of new "innovation" with these vaccines. Why can't we just develop them with the old ways we have done. As you said there are different ways of making vaccines? (in other words, why are there comparatively few inactivated or live-attenuated vaccines being developed against SARS-CoV-2?)

These are older approaches that have been replaced by super-high-end, cutting-edge, highly flexible vaccine platform technologies that are more controllable, predictable, safer, simpler, and manufacturable. Their limited application elsewhere may reflect concerns for the low levels of manufacturing yields, potentially lower immunogenicity in the elderly (i.e. the ability to elicit an immune response), challenging manufacturing requirements (which is key given the scale of the global demand), and putative concerns over safety. Live-attenuated vaccines are the basis of many successful, highly efficacious vaccines. However, the time to develop a live-attenuated vaccine is typically protracted to find the right level of attenuation while maintaining sufficient immunogenicity. For these reasons, the biomedical research field has few live-attenuated vaccines currently in development.

3.12 Why then haven't we made a vaccine for HIV?

Vaccines have worked well against once widespread diseases like smallpox and polio. After the AIDS-causing virus was found, many scientists, thought AIDS would be added to the list. Vaccines mimic natural infections, during which the body produces antibodies that kill the virus. But unlike smallpox or polio, HIV doesn't stimulate this kind of response – our immune systems are generally blind to the virus and unable to launch an effective antibody attack. Other challenges that scientists face as they try to create a vaccine include a lack of good animal models to study and the virus's ability to constantly change and mutate. HIV is particularly good at tricking immune systems. As soon as the virus starts replicating in our bodies, molecules on its surface — which our immune system reads to determine whether a cell is a friend or foe look a lot like other proteins in healthy people. **The resemblance allows the virus to get a big head start on infecting cells before the immune system recognizes a threat**.

Any preventive measure that convinces the immune system to attack this protein in HIV must be fine-tuned. The vaccine will likely deliver tweaked versions of HIV surface proteins. These molecules must be distinct enough from actual HIV for the immune system to recognize them as a threat while also provoking the exact infection-fighting qualities needed to fend off a real infection. Other viruses like COVID-19 don't require vaccine developers to engineer this kind of deception. Additionally, the best defenses our body puts up against HIV (ones the vaccine would like to elicit) appear naturally after a patient's immune system is derelict. These protective tools are called antibodies, which are proteins your body produces in response to an infection — and which can ward off a subsequent infection. (If the term sounds familiar, that's because there's been a lot of talk lately about coronavirus "antibody tests," which are designed to look for signs that a person has begun fighting off SARS-CoV-2.) In coronavirus patients, it seems antibodies appear a few weeks after symptoms kick in. But the kind of antibodies that are most effective in HIV take way longer to appear.

Notwithstanding these challenges, there is continued research in developing an HIV vaccine. Results from previous efforts to build a vaccine have been disappointing. Last year, an HIV vaccine trial in Thailand produced unimpressive results by some measures, the vaccine reduced the chances of infection by 30 percent at most.

3.13 New variants from South Africa. Should I be worried? Is it now locally transmitting in Zimbabwe?

Yes, the new variant 501Y.V2, identified in South Africa has been detected in Zimbabwe. Scientists in South African have demonstrated that there are up to 16 variants that have spread in the country (and perhaps into the region). The arrival of new variants has posed several questions as to the projected effects of the already developed vaccines some of which have shown diminished effectiveness against the new variants and mutations. The vaccine developed by Janssen Pharmaceuticals for Johnson and Johnson has however shown proven protective efficacy against mutation variants. This is the first vaccine to demonstrate protection against the new mutants. Nevertheless, the vaccine's efficacy rate dropped from 72% in the US to 57% in South Africa, where the contagious mutants are driving most cases. This perhaps suggests that these variants also blunt the effectiveness of COVID-19 vaccines made by Pfizer-BioNTech, Moderna, and Oxford - Astra-Zeneca et-al.

SECTION 4
THE PSYCHO-SOCIAL ASPECTS OF COVID-19 WITHIN THE CHURCH

4.1 Situational Analysis

COVID-19 virus has spread at an alarming rate in Zimbabwe during the current second wave. While worldwide 2% of the infected succumb to COVID-19, Zimbabwe's 1103 deaths out of 32 004 infections as of 26th January, 2021 represents a 3% mortality rate from COVID-19. We witnessed an increase 113% in infections, and 203% in deaths in one month.

We acknowledge the positive reductions in the rate of infection as a result of government interventions such as lockdowns, a ban on public gatherings, the closure of public institutions including schools, universities, and churches. Yet the same have had significant negative impacts on the economic and psychosocial wellbeing of individuals, households, institutions, and our congregations.

Lockdowns depress the economic wellbeing of households especially for the poor unemployed, and on those who lose their jobs and incomes in an environment where there are no safety nets. Increased poverty limits the availability of food, thus accentuating malnutrition which compromises the immune systems of household

members, which in turn makes them more vulnerable to both COVID-19 and the many diseases that have always bedeviled the nation. It is a vicious cycle.

The closure of schools has limited education to the rich who can afford on-line learning. The many who suffer from digital poverty have effectively stopped learning thus exacerbating inequalities in education with downstream effects on human development.

The staying together of couples for long durations has been shown to increase gender-based violence, especially against women and girls. Data recorded by five NGOs in Zimbabwe revealed that GBV cases in April-May 2020 increased from 4686 to 6906, respectively - a 47.4% increase in just a month of lockdown.

Given the increased morbidity and mortality within a resource strained context where there is no help of any form around, people are suffering from sorrow, anxiety, depression sometimes leading to suicidal tendencies and mental problems. This is part of the problems and issues that the church deals with with greater success rate than any other institution, sadly the church has constantly been relegated to the "non essential services" division.

4.2 Recommendations

4.2.1 Given the fact that the vaccine, which remains shrouded in controversy, has not yet reached Zimbabwe and the limited capacity of our health delivery system it stands to reason that prevention or reduction *of* infections remains the most important intervention available to combat the COVID-19.

4.2.2 This must begin by educating the nation in general, and our congregants on how COVID-19 is spread. Here are typical COVID-19 spreaders:

- According to WHO the virus spreads mainly through the air when people are near each other. Just one infected person can infect many through breathing, coughing, sneezing, speaking, laughing, or singing.
- It might also spread via contaminated surfaces. Touching such surfaces and then touch one's face leads to infection.
- Any form of gathering can exacerbate transmission of infection depending on the composition of those gathered, their residential locations, modes of transport used, characteristics of the venue, and how the services or functions are conducted. In such gatherings, those infected can infect others whether they are symptomatic or asymptomatic.

4.2.3 Given the above scenario church services, and other social gatherings must observe COVID-19 protocols as determined by the WHO, our Government, and common sense. These include:

- Physical distancing (avoid shaking of hands and hugging totally while maintaining at least 2 meters distance from each other.
- Handwashing and sanitizing.
- Congregants must avoid loud vocalization (loud singing and praying together) and the use of decontaminated microphones.
- Churches must be as well ventilated as possible.

4.2.4 Thus, each assembly has to assess the pros and cons of gathering its people versus undertaking services on-line, as has become the new norm across institutions and business enterprises, and schools. The assessment must take cognizant of the super-spreader factors mentioned above.

4.2.5 The Church needs to assist its congregants to deal with the psycho-social impacts of the pandemic. For example:

- Education by on-line platforms and pamphlets.
- The Church needs basic information on home care and to figure out the extent to which it can help some of its members who cannot afford isolation within their residential places.
- Sermons and lessons aimed at mitigating problems such as GBV during lockdowns are also needed.

4.2.6 The medical fraternity is to be implored to research local practices used for the prevention and treatment of COVID-19 and give the church and the public the necessary facts. Their consistent high-handed dismissal of local remedies which most people can use and are available does not help the country.

4.2.7 We request the Government to increase testing services to the general public and to expeditiously approve medicines that can be used in the treatment of COVID-19.

4.2.8 We further request the Government to cushion the poor and vulnerable by providing the necessary safety nets. Lock-downs without Government cushioning are not practical as they cannot be adhered to by hungry people.

4.2.9 The myriad direct and indirect problems caused by COVID-19 which range from illnesses, loss of family members through bereavement, and loss of livelihoods culminating into GBV in some instances, all demand psycho-social counselling and livelihood support from the churches. **It is therefore recommended that segments of the church which include pastors, elders and deacons be considered providers of essential services requiring commensurate freedom and support to render such services**. Government could also make access to the use of national radios and television easier and cheaper for the church to meet some of the psycho-social needs identified above.

SECTION 5
VERY STRONG ALTERNATIVE VIEWS, OPINIONS AND CONSPIRACIES IN THE CONTEXT OF COVID-19: ENGAGEMENT AND MITIGATION

5.1 Situational Analysis

Epidemics of the past have always been accompanied by very strong alternative views and opinions and what might be termed conspiracy theories which sometimes combine grains of truth with a lot of misinformation. Fake news, misinformation, and very strong alternative views and opinions have become prevalent in the age of social media and have skyrocketed since the beginning of the COVID-19 pandemic.
Very strong alternative views, opinions and conspiracy theories succeed for various reasons. Firstly, they provide the comfort of an explanation in times of uncertainty and anxiety. Secondly the most pervasive and damaging of alternative views, opinions and conspiracy theories incorporate grains of truth and they, therefore, become believable. Thirdly, these views, opinions and conspiracy theories spread fast because of the uncontrolled use of social media, ours is therefore a very difficult task of fast separating fact from fiction and communicating the truth in regard to postulated global political, economic, and satanic conspiracy agendas and New World Order.

What is at stake during this outbreak is making sure people will do the right thing to control the disease or to mitigate its impact. If people are misinformed, they are unlikely to act appropriately. This poses a serious problem for public health.

But who benefits from this misinformation? Claire Wardle, co-founder, and director of First Draft identifies three aspects: financial gain, political gain, and experimental manipulation. The anti-vaccination industry is a notable example of the first. A report from the Centre for Countering Digital Hate shows that wellness and nutritional supplement companies are major backers of, and directly profit from, anti-vaccination campaigns. Worse, anti-vaccination content reaches up to 58 million online followers and is deliberately retained by social media giants, creating a cumulative advertising revenue of US$1 billion. Such campaigns ride on the fact that hesitancy against one vaccine is quickly transposed onto all vaccines and is excruciatingly difficult to reverse. None of this bodes well for the acceptance of vaccination against COVID-19.

5.2 The role of 5G in the spread of the Corona Virus

Among the very strong alternative views and opinions that have been making the rounds since the advent of the Corona Virus late in 2019 is one that attributes 5G technology to the spread of the coronavirus disease 2019 (COVID-19). This view or theory claims that the 5G telecommunications infrastructure is responsible for the weakening of the body's immune system through the electromagnetic radiation

produced from the 5G towers and devices thus stimulating diseases like COVID-19, cancer, infertility, autism, and even Alzheimer's.

The use of mobile cellular telephone systems has over the decade been growing in terms of adoption and these systems have evolved in many ways to become enabling technologies that present many opportunities for universal wireless connectivity. Starting from the early first generation (1G) systems in the 70's to the current fifth-generation (5G) technology, mobile telecommunications has relied on the use of radio waves to provide the seamless and ubiquitous mobile communications that the world enjoys. Specifically, 5G is the fifth-generation technology for broadband cellular networks and is based on a standard produced by a United Nations umbrella body called the International Telecommunication Union (ITU) which is based in Geneva.

Does 5G Technology pose a health risk? **The simple answer is NO**. The frequencies used in 5G networks use radio waves which fall under what is generally known as radiofrequency range (3 kHz to 300 GHz). The energy carried by frequencies in this range is very small and is non-ionising, meaning it has insufficient energy to break down chemical bonds or remove electrons which can cause damage to living tissue. Since these radio waves are non-ionising, they do not damage the DNA inside cells, as X-rays, gamma rays and UV rays can do. All the frequencies that are allocated for 5G networks, although at slightly higher frequencies than previous networks, are still in this radio part of the electromagnetic spectrum. The radio frequencies used by mobile telecommunications operators are regulated and require a specific licence. These licenses are usually issued by government-owned telecommunications regulators, who are empowered to monitor the use and application of the assigned frequencies, in accordance with global frequency standards. The International Commission on Non-Ionizing Radiation Protection (ICNIRP) is an independent non-profit organization that provides scientific advice and guidance on the health and environmental effects of non-ionizing radiation (NIR) to protect people and the environment from detrimental NIR exposure. This organisation issued a statement in April 2020, which debunked the claim linking the Coronavirus to radiation emitted by 5G devices. There is therefore no evidence that supports the claim that 5G can cause COVID-19 disease or increase its severity.

Zimbabwe does not have any 5G networks deployed. The telecommunications sector regulator has allocated radio frequency spectrum for 4G technology and this is currently deployed together with the earlier 2G and 3G technologies.

5.3 Recommendations

5.3.1 We urge all responsible authorities including church and traditional leaders, government, and civic authorities to expeditiously gather true facts and communicate them to followers so that their choices and behaviour are not misdirected resulting in negative consequences.

5.3.2 All communication media need to be deployed to educate the public to question the veracity of conspiracy by asking basic questions like:

- Who has originated this theory and by what authority do they do so? (like the authority of position, of competence, and of character).
- What is the motive of this theory? For example, is this to advance an economic or a political interest?
- Who are the opponents of this theory and how do they counteract it?

5.3.3 As we approach the Day of the Lord the exponential growth in knowledge predicted as this Day draws ever closer, will lead to unique technological advancements and innovations. But the wise shall understand. (Daniel 12:4, 10)

5.3.4 Technological advancements are not intrinsically sinful but can be applied for good with proper ethical considerations and believers should, without hesitation, embrace the dividend offered by these developments. Our ignorance or failure to fully understand these latest innovations should not drive us to formulate baseless views and positions theories or needlessly vandalize 5G equipment.

5.3.5 It is significant to recognise that all these technologies developed by mankind will, if not righty deployed by believers, be at the disposal of the future world dictator who will seek to stand against our Lord.

SECTION 6
COVID-19 AND ESCHATOLOGY

6.1 Situation analysis

For a growing number of evangelical Christians, COVID-19 is a global crisis of apocalyptic and cataclysmic proportions that represents the meeting point between the dangers associated with the Anti-Christ and the opportunity associated with the imminence of the Second Coming and the establishment of the millennial rule of Christ. One unfortunate characteristic of this end-time thinking, however, is that the perceived dangers far outweigh the opportunities. Instead of the confidence associated with the consummation of Christ's reign, many Christians are filled with confusion, uncertainty, and fear. How have we come to such a position?

Much of the current association of COVID-19 with the end-times teaching of the Bible (what we call biblical eschatology) is derived primarily, but not exclusively, from the

book of Revelations. The apocalyptic interpretations of this book have led to fanciful conclusions which include the coronavirus being the "beast" of Revelations 13:16-18 and the vaccine being the "mark of the beast" (facilitated by the likes of Bill Gates) by which those who take the vaccine are in fact worshipping the beast. Such speculative and fanciful theologizing has similarly surfaced in times of past crises including the Black Death (1347-1352), the Spanish flu epidemic of 1918, and the more recent terrorist attacks of 9/11. All these crises generated the belief that the end of the world was imminent with Scriptures such as the Book or Revelations being quoted in support. Moreover, other historical developments like SIM card numbers, the government-issued social security numbers, chip implants have at one time or another been interpreted as the mark of the beast without which one would not be able to trade. The coronavirus COVID-19, being the most serious global health crisis of our time has just served to heighten the same misguided, fear-inducing interpretation of Scripture.

We offer the following guidance to Christians regarding the association of COVID-19 with biblical Eschatology (end time teaching):

Firstly, there can be no doubt that in Jesus' teaching (Matthew 24:7-13, Mark 13:8 and Luke 21:11) His Second Coming will be preceded by such occurrences as nation rising against nation, famines, earthquakes, and pestilences (disease outbreaks). This is affirmed by Revelation 6:8 – *"I looked, and there before me was a pale horse! Its rider was named Death, and Hades was following close behind him. They were given power over a fourth of the earth to kill by sword, famine, and plague…".* In terms of this clear biblical teaching and the world-wide existential experience typified by COVID-19, we are nearer to the Second Coming of our Lord and Saviour than ever before in world history.

Secondly, when we interpret the book of Revelations in its proper context, we can dismiss the fear of the vaccine as being the "mark of the beast – the 666". The context of the Book of Revelation, written by John who was imprisoned on the island of Patmos, was that of persecution of Christians who refused to worship the emperor. So terrible was the persecution that some ancient texts came to refer to emperors Nero and Domitian as "beasts."[6]. Under such historical conditions of suffering a type of biblical literature called the "apocalypse"[7] arose. This literature revealed God's secret truth to the believers, to encourage them, while at the same time hiding the real meaning to persecutors. Given this context the following two interpretive guidelines on Revelations are necessary:

1. The focus must be on Jesus Christ, the hero of the book, and not on the defeated Satan. This is how the book begins: *"The revelation of Jesus Christ, which God gave him to show to his servants the things that must soon take place".*

[6] Examples are Pliny's *Panegyricus,* and *Sybilline Oraclesi*.

[7] From the Greek word "apokalupsis" meaning "revelation".

2. Because the very genre of the book relies on symbolism a literalistic interpretation of the book can lead to fanciful conclusions that drive Christians into unnecessary fear. For example, since “the beast” is clearly an allusion to the emperor’s claim to divinity (symbolized on Roman coins, statues, images, etc.) then someone in the first century could be said to “take the mark of the beast” only by willingly and willfully rejecting Christ and worshipping the emperor. Those who chose to worship the emperor or any other manifestation of the “Anti-Christ” would fully benefit from imperial commerce, protection, and other benefits. Hence both the “mark of the beast” (Rev 13) and “the seal of the Lamb” (Rev 14) are equally symbolic of one’s allegiance. So, for example, there is no way one can accidentally or unconsciously be given the “mark of the beast” through a coronavirus vaccine. You can only take that mark of the beast only by consciously deciding to curse Christ and pledge devotion to his enemy. Those who choose to reject the vaccine should therefore do so on grounds such as its unproven long-term efficacy and not on the religious ground of refusing the mark of the beast.
3. Thirdly the purpose of biblical eschatology (end time teaching) is not to induce fear, but to motivate us to live today in the light of the glorious hope of the Second Coming of our Lord. This is the burden of 1 Peter 4:7-11.

6.2 Recommendations

6.2.1 Michael *Cooper’s short article “*What COVID-19 Has to Do With the ‘End Times” extracts the following lessons from this passage on how to simply live like Christians:

a) Be alert and sober-minded in prayer: instead of being alarmed we must be calm and controlled by focusing on Christ in our prayer.
b) As good stewards of grace, use our gifts for service: We must edify the body of Christ by speaking God’s Word and serving with God’s strength.
c) The Eschatological Purpose: We pray, love, and serve for the glory of God as we anticipate the consummation of Christ’s rule.

SECTION 7
THE ECONOMIC IMPACT OF THE VIRUS

7.1 Situation Analysis

The COVID-19 pandemic reached the country when it was already experiencing far-reaching challenges, with levels of poverty way above those experienced by any region of the world, including Sub-Saharan Africa. This was further compounded by climatic and economic shocks and late and erratic rainfall during the 2019-20 season. The Zimbabwe Humanitarian Response Plan launched in March 2020, highlighted that 7 million people in urban and rural areas (half the population) were in urgent need of humanitarian assistance, up from 5.5 million in August 2019. The worsening

humanitarian situation is associated with drought and crop failure, the macro-economic challenges facing the country and the austerity measures implemented under TSP, which have directly affected vulnerable households in both rural and urban areas. Essential commodities are a daily challenge for most households as a result of high unemployment and chronic high levels of inflation continue to erode purchasing power. A Tripartite Negotiating Forum document indicates that, 7.7 million people (more than half the population) needed food assistance as at December 31, 2019, and those in extreme poverty having increased from 29% in 2018 to 34% in 2019. Thus, COVID-19 has hit the country when it is ill-equipped with very limited fiscal space following the implementation of austerity measures as well as the re-introduction of a local currency.

The Zimbabwe Humanitarian Response Plan of March 2020 also indicates that at least 4 million Zimbabweans were finding it difficult to access primary health care, with the extreme weather conditions exacerbating health risks, including the risk of diarrheal disease outbreaks, such as cholera and typhoid weighing down on a health delivery system that had been negatively impacted by the economic challenges. With the onset of rains and with much heavier rains being received this year, the spectra of diarrheal outbreaks such as cholera or typhoid could be further exacerbated by lockdown and confinement, especially in poorer and more crowded communities. The social protection measures at the disposal of the government were already weak and ineffective to deal with the scale of the social distress. The Government's response is guided by the Social Protection Policy Framework adopted in 2016 which has five pillars, namely: Social Assistance, Social Insurance, Labour Market Interventions, Livelihoods, and Social Support and Care Services. The Tripartite Negotiating Forum Document identifies several policy framework challenges with respect to:

(i) the self-targeting approach for selecting beneficiaries based on those who come to the District Social Welfare Offices to apply;
(ii) the interventions are only reaching a fraction of those that need help due to limited funding;
(iii) untimely disbursement of funds to beneficiaries;
(iv) low levels of support pegged in ZWL$s in a context of high inflation;
(v) the requirement that recipients should have a registered bank account;
(vi) lack of a management information system (MIS) (no digitization of the records);
(vii) donor support being off-budget and through selected NGOs operating outside of Government structures; and
(viii) very limited coordination between programs, among others.

The TNF document recommends that "a nation's capacity to proactively and effectively respond to crises (e.g. COVID-19) is a function of its social protection and healthcare systems as well as the state of its institutions and infrastructure. Owing to the limited testing and diagnostic capacity in the country, the official COVID-19 figures may understate the true number of infections. Zimbabwe is particularly vulnerable to the pandemic owing to a weak public health system that has suffered from years of gross underfunding.

For Zimbabwe, the COVID-19 pandemic provides a golden opportunity to look inwards for solutions to our development challenges and rethink macroeconomic and development policies. In most advanced economies, the economic response has been quick, decisive, and significant. A number of emerging market and developing economies (such as China, Indonesia, Nigeria, and South Africa) have also unveiled huge economic support.

The 2019 Labour Force Survey has revealed that the share of informal employment to total employment is estimated at 75.6 percent in 2019. Comprehensive social protection systems can help to lessen the fallout from crises such as COVID-19. With about 76 percent of the labour force employed in the informal economy, the lockdown could result in many informal workers and their dependents being driven further into poverty and hunger. This would, directly and indirectly, affect informal workers and their dependents in terms of reduced physical immunity to the virus and reduced ability to access therapeutics or health care.

At the beginning of April, the government announced a ZWL$600 million (US$25 million) package to be extended to small businesses, vendors, and the elderly to compensate for the loss of income during the COVID-19 national lockdown. There have however been delays in the disbursements of funds.

7.2 Recommendations

7.2.1 Social dialogue is important in coming up with sustainable solutions to various political and economic crises as well as accelerate recovery from the crises and it is increasingly clear that governments can neither tackle the causes and consequences of the crises nor ensure social stability and economic recovery through unilateral action. Although challenging to undertake due to diverging views of social partners, consultations and negotiations remain the way to go to reach national consensus and unleash national resources for resilience and energy to combat crises. In the context of the COVID-19 pandemic and lessons learned from past social dialogue experiences, the ILO 26 provided eight lessons six of which are relevant to this discussion:(TNF Document)

a) Countries having experience of social partnership and well-established social dialogue institutions are more likely to formulate rapid and effective responses.
b) Governments should involve the social partners at the earliest possible stage of crisis response.
c) The social partners should be proactive in quickly bringing the concerns of actors at the grassroots level to the attention of the public authorities.
d) With political will, the social partners can achieve consensus on targeted measures to help citizens and enterprises particularly hard hit by the crisis.

e) The crisis context can even provide an opportunity to overcome previously adversarial industrial, social and political relations.
f) While social dialogue is an important tool for bridging differences and building consensus, it cannot solve all the problems on its own. Sound public policies and regulations and appropriate fiscal space are especially crucial in the crisis context.
g) Free, independent, strong and representative employers' and workers' organizations, trust among the actors and respect by the Government for the autonomy of the social partners are essential preconditions for effective social dialogue;

SECTION 8
TASKFORCE CONCLUDING REMARKS

8.1 Areas of concern identified

A number of areas were identified that have a bearing on or are influencing or influenced by the current COVID-19 context outlined above and the issue of vaccines and vaccination roll out.

a) The issue of the nature of the Corona Virus and its medical and scientific development (the time taken to develop the vaccine, the nature of the vaccine, the human trials, the unknown after effects, etc.).
b) The issue of the economic impact of COVID-19 on Zimbabwe currently and in the foreseeable future.
c) The issue of overall management of COVID-19 response regarding preparedness, policy formulation, institutional and prophylactic management, and the effectiveness of COVID-19 protocols in Zimbabwe.
d) The Management and mitigation of social impact of COVID-19 including family, marital and mental health.
e) The management and mitigation of COVID-19 on education and current online schooling.
f) The vibrant and viral Eschatological interpretations deriving from COVID-19.
g) Engaging with and mitigating the very strong views and opinions vis the COVID-19 as a pandemic or plandemic -The very difficult task of separating fact from fiction regarding postulated global political, economic, and satanic conspiracy agendas and New World Order(666).

8.2 Outcomes

8.2.1 The major outcome of this document is to provide information, knowledge, and objective analysis of the current COVID-19 context to assist Church Leaders and their Churches to make individual and informed decisions on the scientific, medical, and ethical integrity of the drug and vaccine development process, the potential benefits

and risks therefrom and the acceptability of the developed vaccines or drugs for use for vaccination.

8.2.2 This report holds no brief nor prejudice for a particular decision or position and will leave that to church leaders and their denominations. As in any unfolding and recently developed situation, there are pros and cons to any perspective that can be offered. This report has attempted to factor in the most significant of these pros and cons without taking a value judgment.

8.2.3 The recommendations of this task force are contained within this report and at the end of each section but more specifically in the Executive summary of recommendations at the beginning of this report.

We trust that the information contained herein will assist Church leaders and the Church to have a clearer understanding of the issues surrounding COVID-19 vaccines and vaccinations and thus make the best decisions and choices they deem fit.