



## **INQUIRY INTO ENSURING FREE AND FAIR LOCAL GOVERNMENT ELECTIONS DURING COVID-19**

**ATT: JUSTICE DIKGANG MOSENEKE**

**JUNE 21, 2021**

Sir

We are pleased to respond to your request for comment related to the subject of your inquiry and thank you for the opportunity to provide expert medical and scientific opinion relevant to holding the local government elections in October 2021.

We understand the concerns and the exigencies attending the holding of elections during the COVID-19 pandemic and hope that the information provided goes some way towards creating greater understanding of the risk matrix for the event.

At the outset, we make common cause with the need to hold elections with regularity and in consonance with the Constitution of the Republic. The IEC has an obligation to conduct these elections and appears to have preparations well in hand.

### **SITUATION ANALYSIS**

1. The pandemic has roiled societies around the world for the last eighteen months and, barring a few developed nations, the overwhelming majority of the planet remains firmly in the grip of the pandemic at this time. Consequently, our views and forecasts are shaped by the scientific, epidemiological and healthcare implications of the pandemic and the measures required to attenuate its impact.
2. Of course, necessary societal functions have to continue during the pandemic and these elections fall into that category. In the event, it is necessary to juxtapose the conduct of the elections against the known and forecast effects of transmission of the viral pathogen, SARS-CoV-2, during the period, especially its designated Variants of Concern.
3. The national response has revealed deep dysfunction in governance, poor state capacity and an overweening political interference in what should be regarded as a public health emergency. On these metrics, SA's response is a cause of great concern.
4. While lockdown restrictions are ostensibly based on a "risk-adjusted strategy", the predominantly inchoate nature and enforcement of these restrictions have had the unfortunate effect of causing severe collateral economic and social harm. An ineffective communication strategy has led, in many areas, to poor compliance with personal protective measures and behavioural modification.
5. Of greatest concern is the lackadaisical approach to the most important intervention, viz. vaccination at scale, to protect the population and move the country beyond the emergency phase of the pandemic. Currently, SA has one of the lowest rates of vaccination in the world and of the highest rates of C19 fatalities, an alarming correlation that has major human rights implications.

6. The official estimates and reports of cases of infection, hospitalisation and deaths are based on reports from health facilities and collated daily by the National Institute of Communicable Diseases (NICD). These numbers do not include deaths and cases of the illness that have not been laboratory tested, resulting in a significant undercount. The registration of deaths by the Department of Home Affairs has a two-year backlog, making an accurate assessment of mortality from specified causes inordinately difficult.
7. **Excess Mortality:** The SA Medical Research Council has a reliable and long-standing surveillance programme which measures mortality rates and projects these rates for an impending year, based on historical data and corrected for demographic changes.

In normal times, the total number of deaths from natural and non-natural causes do not change much year-on-year, unless events occur or large movement in the age or demographic profiles of the population are altered significantly. The difference is expressed as Excess Mortality rates, being the number of deaths that occur above the projected estimates for the period.

Because the MRC counts all fatalities from facilities, mortuaries, undertakers, police reports, etc, it has a fairly accurate picture of the number of excess fatalities at any given time. Ascribing the cause of these fatalities to an identifiable change in the expected environment, such as during sudden widespread conflict or an epidemic is fairly straightforward in the absence of any other legitimate causes.

The official mortality rate from C19 for the period currently stands at just over fifty-eight thousand (58,000). Excess natural deaths for the period of the pandemic are approximately one hundred and eighty thousand deaths (180,000).

The advent of COVID-19 is the only identifiable cause of these deaths above the projected norm, corrected for other causes of deaths. It is extrapolated that at least 80% of the excess fatalities can be ascribed to C19.

The remaining numbers are ascribed to the increased mortality among those afflicted with AIDS, TB and other communicable and non-communicable diseases during the period of the pandemic, which revealed significant reductions in health-seeking behaviour or unavailability of healthcare services, resulting in higher mortality rate in this cohort. However, the significant reduction in deaths from seasonal influenza and other diseases due to the non-pharmaceutical interventions imposed during C19 offsets the increase in the number of natural deaths from the aforementioned causes.

It can, therefore, be stated with a high degree of certainty that the overwhelming number of excess fatalities of one hundred and eighty thousand can be positively ascribed to C19 and that this number reflects the true rate of mortality from C19.

8. SA is currently experiencing the resurgence, or 'Third wave', of transmission of the virus, The rate of increase of positive cases, illness, hospitalisation and fatalities is consistent with a sustained resurgence of the pandemic. Best estimates currently point to the magnitude of this resurgence exceeding the previous two waves. As of even date the third wave has already delivered higher numbers of cases than the preceding waves. the correlated death rates lag infection by about two weeks and can be expected to follow a similar trajectory, although greater accessibility of oxygen, more experience in treatment and possible immunity from previous infection may attenuate this.

9. The major characteristics of this resurgence are related to, inter alia, the cyclical, mainly seasonal, surge and ebb of waves of viral respiratory infection; the emergence of variants of the virus that demonstrate greater transmissibility and virulence; the degree of waxing and waning immunity from previous infection; protective personal and state-mandated non-pharmaceutical interventions; and, of course, the rate of vaccination of the population.
10. Surges during colder seasons is typical of respiratory viruses such as SARS-CoV-2, mainly due to greater indoor confinement, with more crowding and greater proximity providing increased opportunity for airborne transmission of the virus. In warmer months, there is a significant ebb in transmission, with distinctly lower levels of circulating virus.
11. This is by no means the only variable, however. In the case of this novel coronavirus, which has often upended orthodox expectations, seasonal symmetry is by no means absolute. SA's so-called 'Second Wave', occurred during the height of summer, from late November 2020 to early February 2021.
12. This was the consequence of two drivers of infection, each playing a significant and inter-related role. The first was the emergence of the viral variant 501Y.V2, or the Beta variant, which has proved to increase transmissibility, both due to more efficient transmission, as well as an increased ability to evade neutralising antibodies from previous infection and reduced vaccine efficacy (this latter effect was not significant because SA had not yet begun its vaccination programme).
13. The second driver of infection during the second wave was the numerous gatherings during the festive period, which created the ideal conditions for the Beta variant to spread exponentially. These 'super-spreading events' were widely distributed, resulting in large and simultaneous outbreaks throughout the country's coastal provinces initially, spreading later to the more inland provinces. By all measures, this second wave was more severe and debilitating to the healthcare system than the first wave during the winter months of 2020.
14. Given that the major circulating strain of SAR-CoV-2 in SA currently is the Beta variant, the third wave shows every sign of matching the amplitude (height) and wavelength (duration) of the second wave. The circulation of the Alpha strain, first identified in the UK, was fairly low during SA's second wave, but is showing signs of slightly greater prominence in SA during this wave, but it is unknown at this time whether it may be contributing to the resurgence.
15. The Delta variant, recently identified in India, has shown alarming rates of transmissibility and virulence and is now the dominant strain in the UK, eclipsing both the Alpha and Beta variants there. The Delta strain is also presently circulating in SA, albeit at low levels. This is particularly important to note, in that it may increase in dominance in SA later this year.
16. There are early indications that, in inland provinces at least, the peak of this Third Wave may exceed that of the Second Wave, with its attendant consequences for the population, the healthcare system and the economy.

On this last matter, it should be noted that the government has little or no room to further restrict economic activity without causing great financial and material distress to people and lasting economic harm. This accounts for its fairly light touch restrictions currently, which may well have to be revisited should healthcare services be overwhelmed.

17. Current restrictions limit gatherings to fifty persons indoors and one hundred persons outdoors. In order to attenuate the effects of this resurgence, our view is that, for the duration of the surge, there should be a blanket prohibition on all non-essential gatherings, including religious, sport, cultural and similar events where there are more than twenty people present.
18. This does not apply to C19-compliant workspaces, public transportation or schools. That being said, current policy on allowing full occupancy in taxis poses a material risk to both commuters and drivers, more so during the winter months when air circulation and ventilation in vehicles are curbed.
19. As for schools, the scientific consensus is that children are mostly asymptomatic if infected, are very poor transmitters of the virus and do not pose a risk to adult staff, provided that personal protective measures are diligently applied. Infection in pupils and adult teaching staff occurs overwhelmingly in community settings, not at school. This points to the need for greater adherence to personal protective measures by teachers and greater parental control over children gathering with others outside of school. School closures may be necessitated if the surge in infection is so excessive that a broad limitation on all movement becomes necessary.
20. While many countries have held elections at various times during the pandemic, their experiences of creating a risk of greater transmission is mixed. This is primarily reflected through the different socio-economic conditions of different countries, their relative rates of vaccination, the prevalence of Variants of Concern (Alpha-UK, Beta-SA, Gamma-Brazil, Delta-India), size and homogeneity of populations, percentage turnouts, electronic voting and the efficiency of in-person voting.

## **COVID-19 RISK MATRIX FOR LOCAL GOVERNMENT ELECTIONS**

From the foregoing, we can extrapolate the following risks attending the holding of elections in October 2021.

### **A. To The Hustings**

The current levels of lock down and attendant restrictions are likely to remain in place for at least four to six weeks, up to end-July, at least. Political parties engaging in electioneering are likely to do so during the months of August, September and October, when, it is hoped, the rate of infection will be much lower and restrictions will be eased.

It is very difficult to predict with any level of certainty that circulating virus during this period, with a forecast based on historical trends, will be at the level of previous troughs. Even though October is the beginning of the summer months, the natural seasonal abatement of circulating virus may be confounded by the emergence of new variants with greater transmissibility (the Delta variant is 64% more transmissible than the Alpha variant in the UK and both of these are currently in circulation in SA, where the Beta variant remains dominant for now).

Moreover, the resumption of non-essential activity and gatherings, which will follow the lifting of restrictions during this period, has previously been shown to be a proximate cause of non-seasonal resurgence, as witnessed during the last wave. (cf. Points 10-13).

The voter registration programme planned for July 16 and 17 is going to fall squarely during the peak or cresting of the current wave and poses a material risk, if not from the registration venues, then from the concomitant movement of people during that time.

It is to be expected that the pressure from political parties to undertake political activity such as rallies and community mobilisation during August, September and October will be high. These events are virtually certain to be direct causes of greater transmission.

**B. Voting on October 27**

If the run-up to the plebiscite will increase the likelihood of greater transmission, then the actual act of voting will have its own itinerant risks. Getting to voting stations will necessitate the use of public transport for most voters and the mingling of people prior to arriving at voting stations creates a higher probability of transmission.

The IEC has, reportedly and in its submission, rightly confined its responsibility to ensuring that voting stations are oriented towards proper C19 compliance. We are confident that the IEC has the wherewithal to ensure the venues are safe.

However, on the balance of probability, having uniform adherence across twenty-three thousand-odd voting stations will not be possible and, even if any lack of adherence is confined to a minority of stations, these may well be sites of accelerated transmission.

**C. Post-election Pandemic Resurgence**

Given that in the majority of elections held internationally there was viral resurgence, to greater or lesser extent, depending on the factors mentioned in points 9 and 20 above, in the period following elections, there is absolutely no reason to believe that SA will escape such a fate.

Even with the expected uptake of vaccinations following the error-prone effort thus far, by the time elections are held there will be insufficient viral suppression to escape the high probability of a post-election surge.

In this regard, the high number of breakthrough infection among vaccinated people is a function of an understandable but false belief among many that being vaccinated means that one may dispense with personal protective measures and minimising contact with others. Indeed, the current generation of vaccine candidates provides strong protection against severe disease, hospitalisation and death, but is much less efficacious in preventing mild or moderate disease.

While those who have been vaccinated may escape serious illness, they will remain prone to infection and transmit the virus to others. This means that, to all intents and purposes, those who have received at least one inoculation will have to continue with taking all the necessary precautions.

While it is possible that SA may experience such a low level of circulation that any post-election resurgence will be negligible, this has not been documented elsewhere. It is, therefore, not a reasonable expectation, all else being equal, in South Africa.

The following are responses to the specific queries outlined in the invitation for submission:

- The challenges posed by the COVID-19 pandemic have been outlined in broad terms in the foregoing sections. Much detail, epidemiological, clinical and sociological, is available to support the contentions made and will be provided at your request.

The current measures promulgated by the government require, first, a high degree of compliance in the population and, second, a highly effective vaccination programme.

As the evidence shows, SA is a low-trust society and the state's exhortations to the populace to comply is, more often than not, observed in the breach. This is a long-term problem and significant behaviour change is not likely in the short term.

The lethargic vaccination drive will eventually pick up pace with the arrival of greater vaccine supply but will not have a material impact on transmission due to both lower efficacy against mild and moderate illness and insufficient population-level immunity by the time of the elections.

- The IEC faces a conundrum. Despite its obligation to conduct the poll and its comprehensive measures to protect people at voting stations, as well as its staff infrastructure during the ballot and the post-ballot counting, it is not in a position to significantly alter the risk patterns of political hustings, rallies and the movement of people during that period and on voting day.

Consequently, while its remit in maintaining free and fair elections is, as can be seen, satisfied, the risks posed by C19 to the population as a result of the poll, however, is extraneous to that remit. This must be the concern of the executive and legislature.

This inquiry is vital to inform those organs of the government of these risks so that they can determine what mitigation they may need to engineer to reduce the risk to acceptable levels. In the circumstances, it is difficult to see what more can be done in the time remaining before the elections.

- Apart from the information provided above, data analysis is appended for further elucidation of the risk matrix.
- Information contained in points 3 to 10 are relevant to this query. As stated previously, best estimate forecasting is based on historical information and epidemiological projections. The behaviour of this novel virus has been unpredictable at times, but not eccentric. It bears the characteristics of highly contagious respiratory pathogens and, where its behaviour evidenced aberration, the causes have been identified and the behaviour explained. This is outlined in points 12 and 13, in particular.
- The late initiation of vaccination, the failure to procure sufficient supply and low vaccination rates have been documented and the government continues to struggle with these matters, most, if not all, being of its own making. Taking the view that lessons have been learned, it is reasonable to expect that, once vaccine supply is stabilised, the rate of vaccination will increase significantly during the third quarter. Definitive detail on supply will probably emerge by the end of June.

- By mid-October, four months hence, given the variables, progress from the current sub-two percent of the population being vaccinated to something approaching 20% is feasible under the current conditions. Unpredictable constraints in supply represents the major risk factor in this regard. The administration of inoculation is less likely to pose an appreciable risk, given the close collaboration between the public and private health services.

Community, or herd, immunity is reached when the amount of circulating virus is insufficient to cause spread, viz. when the reproductive rate, or 'Ro value', of the virus drops below 1. This will mean that an infected person will not be able to infect more than one other person, if that. This can be expected to eventuate once 70% (40-45 million people) of the population is inoculated.

However, as noted above, the current generation of approved vaccine is not expected to provide appreciable herd immunity, due to the lower efficacy of the candidate vaccine to prevent mild and moderate illness. While vaccination will have a hugely positive impact on rates of severe illness, hospitalisation and death, circulating virus will continue to be widely transmitted and may cause mild or moderate illness among those already vaccinated and potentially severe illness or death among those not yet vaccinated. This will necessitate the prolongation of restrictions and personal preventative measures will have to be continually applied.

Public health policy is following this protocol worldwide. Vaccine manufacturers are racing to produce the next generation of C19 vaccine, which will provide protection from the existing Variants of Concern (VoC) identified by the WHO, but their introduction will probably only occur in the third or fourth quarter of 2022, at the earliest. In the meantime, the risk of more VoCs emerging will be a direct function of the amount of viral circulation, the force of infection in this and subsequent waves and the prevailing rate of vaccination.

To the point in the query, then, it is fair to aver that there will be no herd immunity by the end of October 2021.

- This is the pointed query that goes to the nub of the issue. If the local government elections were to proceed under the conditions expected, as best estimated, to prevail during late October and, to the extent that extraordinary measures are not in place, there is significant risk of a surge in transmission and, consequently, a high risk of illness and death as a result.
- In the event that the poll must, out of unavoidable necessity, proceed, then mitigation measures beyond what the IEC has already determined, will have to include one or more of the measures listed below.
  - A total prohibition of political rallies and attendant activity conducted in the normal course at open-air or indoor venues, in keeping with current regulatory restrictions. In this regard, it must be noted that the restricting indoor gatherings to fifty people and one hundred persons outdoors is insufficient to limit the epidemiological rate of transmission, even at these levels, significantly.
  - Accelerating the migration to electronic registration and creating opportunities to reduce in-person voting. In the remaining period, there is probably not much that can be done to implement these measures. However, it is noteworthy that, in the US, local and state elections where there was a higher rate of electronic voting, this was correlated with little increase in transmission and illness in the post-election period.

- Constitutionally compliant postponement of the elections until, at least, the vaccination rate produces significant levels of community immunity must be a consideration.
- Please find relevant data sheets annexed.

## **CONCLUSION**

We remain bound by the ethical code as healthcare professionals to be true to the best interests of the health and well-being of the people and to protect them to the best of our ability from C-19.

We affirm our support for the constitutional imperative to hold the local government elections at the appropriate time and in the prescribed manner. The responsibility of those charged with the decision on whether to proceed with the holding of the polls and under what conditions is immense.

It is our considered opinion that C-19 poses significant risk to the health and lives of the electorate during the period preceding, during and after the poll and consideration must be given to either postponing the poll, or, if that is not feasible or constitutionally compliant, to take such measures as outlined above, bearing in mind that proceeding with voluntary activity that poses a risk of avoidable illness or loss of life does, in our humble view, offend the ethical code.

Free and fair elections are measurable and may be declared as such, or not, as the case may be. During a pandemic, the risk to life from illness and death from C-19 that an election may cause may be similarly measured and must, in our view, be included in the overall assessment. It will require considerable wisdom to apply a proper weighting of appreciable harm to the well-being of people in order arrive at a reasonable conclusion that a free and fair election still obtained.

We have reached these conclusions following a review of the last eighteen months since the pandemic was declared, the particular circumstances prevailing in South Africa during this period and after wide consultation with recognised experts in the field, both from within the ranks of and associated with the Progressive Health Forum.

We are hopeful that our modest contribution to the analysis of the risk posed by the pandemic during the elections will assist those who must take the difficult decisions to proceed with and to evaluate whether the poll was free and fair.

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