Submission on Proposed Regulations in terms of the National Health Act

15 April 2022

1. Introduction

1. Africa Criminal Justice Reform (ACJR) is a project of the Dullah Omar Institute for Constitutional Law, Governance and Human Rights at the University of the Western Cape. ACJR seeks to carry out engaged research, teaching and advocacy on criminal justice reform and human rights in Africa.

2. This submission is in relation to draft regulations published in Gazette 46048 of 15 March 2022 ("the draft regulations").

3. These draft regulations are widely understood to be proposed to be used in relation to Covid-19.

4. In broad terms the proposed regulations will, to a greater or lesser extent, impose limitations on personal liberties. Such limitations must at all times be assessed objectively against the limitations clause in the Constitution, providing that rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including -
   - the nature of the right;
   - the importance of the purpose of the limitation;
   - the nature and extent of the limitation;
   - the relation between the limitation and its purpose; and
   - less restrictive means to achieve the purpose.

5. Whether the limitation is justifiable or not therefore will depend on facts and not only the law.

2. Covid-19 immunity in South Africa

6. Covid-19, before the arrival of vaccines, had an estimated median Infection Fatality Rate (IFR) of under 1 percent (deaths of all persons infected, including asymptomatic): the IFR was estimated at 0.466% early on in the pandemic, reducing to 0.314% later. [1]

7. IFR is different from the Case Fatality Rate (CFR) (deaths of known cases, usually in hospital), which tends to be much higher.

[1] 'Variation in the COVID-19 Infection–Fatality Ratio by Age, Time, and Geography during the Pre-Vaccine Era: A Systematic Analysis', *The Lancet*, 24 February 2022, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02867-1/fulltext#seccestitle10.

8. The implication of the IFR, is that the estimated number of excess mortality deaths in South Africa (more than 300 000)[2] which experts say are attributable to Covid-19, suggests that vast majority of the population has likely already been infected.[3]

9. This is because if all South Africans were infected, this high number of deaths would imply an IFR of 0.5 percent, which is already above the high estimate pre-vaccine IFR. If a number fewer than all South Africans were infect, it would suggest a higher still IFR, higher than most estimates.

10. Further evidence of high exposure comes from antibody studies. An antibody study from November 2021 suggests more than 71% of South Africans have antibodies.[4] Unlike T-cell immunity, antibodies wane.[5] This means more people than the number with antibodies may have immunity. Consequently, it can be estimated that between 71% and 100% of South Africans have some immunity.

11. This suggests that South Africans now have a significant degree of natural immunity, not only via antibodies, but also via T-cell immunity, which is long-lasting and cross-reactive to different variants of the virus.[6] While re-infection is possible, it is less likely to cause serious illness and death if there is such cross-reactive immunity.

12. In addition, 44% of the adult population (as at early April) is fully vaccinated, providing additional protection.[7]

13. Accordingly, it is likely South Africa has moved beyond the epidemic phase of Covid-19 and deaths will become increasingly uncoupled to the number of infections. This means infections are likely to rise and fall, but serious illness and death will not rise to the same degree as previously. This was evident during the fourth wave of infections in December 2021 and January 2022. [8]

14. **This implies extraordinary measures are no longer, if they were ever, appropriate, in relation to Covid-19**.

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[2] 'South African Medical Research Council - Report on Weekly Deaths in South Africa', accessed 2 April 2022, https://www.samrc.ac.za/reports/report-weekly-deaths-south-africa.

[3] T Moultrie et al., 'Correlation of Excess Natural Deaths with Other Measures of the COVID-19 Pandemic in South Africa' (Cape Town: SAMRC Burden of Disease Research Unit and UCT Centre for Actuarial Research, 23 February 2021), https://www.samrc.ac.za/sites/default/files/files/2021-03-03/CorrelationExcessDeaths.pdf.

[4] Cable R et al., 'Estimates of Prevalence of Anti-SARS-CoV-2 Antibodies among Blood Donors in Eight Provinces of South Africa in November 2021', *Research Square*, 15 February 2022, https://doi.org/10.21203/rs.3.rs-1359658/v1.

[5] B Meyer, 'Waning Antibodies to SARS-CoV-2 – Don't Panic', *The Lancet Regional Health*, 5 May 2021, https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00092-2/fulltext.

[6] P Moss, 'The T Cell Immune Response against SARS-CoV-2', *Nature Immunology* 23 (1 February 2022): 186–93.

[7] 'COVID-19 Latest Vaccine Statistics', accessed 6 April 2022, https://sacoronavirus.co.za/latest-vaccine-statistics/.

[8] SA Madhi et al., 'Population Immunity and Covid-19 Severity with Omicron Variant in South Africa', *The New England Journal of Medicine*, 23 February 2022, https://www.nejm.org/doi/full/10.1056/NEJMoa2119658.

3. Empowering legislation

15. The Minister seeks to make the proposed regulations via:

    a. section 90(1) of the National Health Act, which provides that the Minister, after consultation with the National Health Council and Office of Health Standards Compliance, may make regulations in relation to (j) communicable diseases (k) notifiable medical conditions and (w) "generally, any other matter which it is necessary or expedient to prescribe in order to implement or administer this Act" , to be read with

    b. section 90(4), which provides that the Minister must publish draft regulations at least three months before their proposed implementation date; may alter the draft after comment without publishing changes; and may dispense with the three-month requirement, "if circumstances necessitate the immediate publication of a regulation."

16. Accordingly, **the earliest the any regulations may legally come into effect, unless the Minister can show that "the circumstances necessitate" a reduced time period, is three months after 15 March 2022** i.e., 15 June 2022.

17. It is not obvious that any circumstances exist which would necessitate a failure to allow proper consultation on these regulations.

4. Existing regulations

18. The Minister seeks to amend existing regulations contained in GN 1434 of 15 December 2017: *Regulations relating to the surveillance and the control of notifiable medical conditions* (Government Gazette No. 41330) (the "2017 Regulations").

19. These regulations already provide comprehensively for the management of notifiable medical conditions. Critical questions must therefore be raised about the motivations underlying the proposed regulations and what they aim to achieve.

20. Existing Regulation 14, for example, labelled "Voluntary medical examination, prophylaxis, treatment, isolation and quarantine" already provides that a carrier "must" subject him or herself to examination, and that the carrier "must" comply, to the best extent possible, with all infection control measures given, including but not limited to prophylaxis, treatment, isolation or quarantine measures.

21. Existing Regulation 14(9) provides that for the above to apply, the notifiable medical condition must pose a public health risk and "the person who is a case, carrier or contact of a notifiable medical condition has been offered and encouraged to accept counselling services in order to assist him or her to understand the nature of the voluntary measures, the personal health risk and the public health risk."

22. Existing Regulation 15 provides for "Mandatory medical examination, prophylaxis, treatment, isolation and quarantine." It provides for obtaining a court order should a carrier refuse to submit to the voluntary measures outlined above. Measures to prevent transmission can take place in advance of the court order. However, such mandatory measures can only take place if the following conditions are met:

    a. the notifiable medical condition must pose a public health risk

    b. the person must have expressly, impliedly or by conduct refused voluntary measures to protect public health

    c. consent in terms of section 7 of the Act could not be obtained (section 7 provides for the situation of a person unable to give consent)

    d. the person who is a case, carrier or contact of a notifiable medical condition has been offered and encouraged to accept counselling services in order to assist him or her to understand the nature of the voluntary measures, the personal health risk, the public health risk and the procedure that will be followed should he or she refuse voluntary measures.

23. In our view, these existing regulations provide a better balance between the interests of public health and constitutional rights.

24. Four categories of notifiable medical condition have already been declared by the Minister under the 2017 Regulations, contained in Tables 1, 2, 3, 4 of Annexure 1 respectively.

25. In addition, the Minister may under Regulation 12 declare by Notice in the Gazette, a condition not contained in Annexure 1, as notifiable if in his or her opinion the medical condition—

    a. poses a public health risk to a population of a particular community, district, municipality, province or the country;

    b. may be regarded as a public health risk or has a potential for regional or international spread; and

    c. may require immediate, appropriate and specific action to be taken by the national department, one or more provincial departments or one or more municipalities.

26. Regulation 12 therefore allows new diseases to be added to the list when necessary.

27. Existing Regulation 12(3) provides that the Minister may determine, by Notice in the Government Gazette, that—

    a. certain diseases or medical conditions be notifiable in certain provinces, districts or municipalities, for a period specified in the Notice or until the Notice is withdrawn;

    b. certain diseases or medical conditions be notifiable by certain categories of health care providers, pathologist or laboratory personnel; and

c. specific diagnostic or laboratory criteria apply to specific diseases or medical conditions.

28. It is unclear whether Regulation 12(3) applies to all notifiable medical conditions or is only intended to apply to a smaller subcategory for which temporary measures apply. In any event, it provides for different measures in different parts of a country for a new declared disease.

29. The first two categories in Annexure 1 impose reporting obligations on both laboratories and health care providers, while the second two relate only to laboratories. The categories are as follows:

    a. Category 1 in Table 1 refers to conditions requiring immediate reporting on diagnosis by the "most rapid available means" and covers 22 conditions at present, including Measles and Rabies in humans.

    b. Category 2 in Table 2 refers to conditions requiring written or electronic notification within 7 days of clinical or laboratory diagnosis by public and private labs and by health care providers, and covers 21 conditions, including Hepatitis and Tuberculosis;

    c. Category 3 in Table 3 refers to conditions and associated pathogens requiring written or electronic notification within 7 days of clinical or laboratory diagnosis by public and private labs, including Rubella (7 conditions and associated pathogens)

    d. Category 4 in Table 4 refers to conditions and associated pathogens requiring written or electronic notification within 30 days of clinical or laboratory diagnosis by public and private labs, covering Health care-associated infections or multi drug-resistant organisms, including Vancomycin-resistant enterococci (6 pathogens).

30. Item 18 of Table 1 refers to "Respiratory disease caused by a novel respiratory pathogen" with the asterisks stating "Examples of novel respiratory pathogens include novel influenza A virus and MERS coronavirus." It is understood that Covid-19 falls into this category.

31. The proposed regulations apply to categories 1 to 3 of notifiable medical conditions in tables 1 to 3. In other words, they will apply to Covid-19 and any of the conditions in Categories 1 to 3. They do not apply to category 4.

32. The 2017 Regulations provide for offences in Regulation 20. The formulation is extremely broad, providing for **a sentence of up to 10 years' imprisonment or a fine** (no maximum specified) for any person who "fails to comply with a provision of these regulations". Accordingly, this will apply to the proposed regulations too.

33. It is the view of ACJR that **using criminal law and criminal justice system processes to manage public health problems leads to absurdities and unintended consequences**, and is in general inadvisable, not least because public health is built on trust and voluntary co-operation of the public. Moreover, as noted in the Introduction, limitations on personal liberties must be thoroughly assessed against limitations requirements set in the Bill of Rights as well as constitutional jurisprudence.

34. Our work in South Africa and several other African jurisdictions has repeatedly found that placing a requirement on the statute books does not mean that reality changes. There are simply too many other variables mediating the effect of law on society and more specifically on people's behaviour. The fact that torture is prohibited under international law (carrying the status of *ius cogens*) and by the Constitution (permitting no derogation) and it is criminalised in statutory law[9] does not mean it does not happen. Regrettably, there is indeed every reason to conclude that it is on the increase.

35. The over-regulation and criminalisation of behaviour unfortunately creates opportunities for the misuse of power, in particular the power to arrest without a warrant. For 2020/21 SAPS reported that it executed 1.6 million more arrests compared to the previous year,[10] but this did not result in more prosecutions, a safer society and increased trust in the police; rather the contrary.

36. Imposing public health interventions with the threat of arrest and imprisonment undermines trust.

37. In general, **there needs to be a shift from the legal and punitive enforcement of restrictive public health measures, which have harms and perhaps limited utility, to public education, trust-building, adequate treatment of the ill, humanity, and personal responsibility**.

5. Proposed regulations 15A – 15H

5.1. Unconstitutional

38. The draft regulations propose to insert regulation 15A, which provides that any person who is confirmed or suspected carrier or has been in contact with any person who is a carrier of a condition contained in categories 1 to 3 contained in Tables 1 – 3, **may not refuse to submit to**:

    a. A medical examination

    b. Admission to a health establishment, quarantine, or isolation site

    c. Mandatory prophylaxis, treatment, isolation or quarantine in order to prevent transmission.

39. Prophylaxis is prevention. The prophylaxes available for Covid-19 are the various Covid-19 vaccinations.

40. Isolation is for people who are ill, while quarantining is for people who have been exposed to ill people.

[9] 'Prevention of Combating and Torture of Persons Act 13 of 2013' (2013), https://www.gov.za/documents/prevention-combating-and-torture-persons-act.
[10] 'South African Police Service Annual Report 2020/21', Annual Report (Pretoria, 2021).

41. These provisions clearly infringe the right to dignity contained in section 10 of the Bill of Rights in the Constitution, right to freedom of movement contained in section 21, and the section 12 right to freedom and security of the person, including the right to bodily integrity contained in section 12 (2) of the Constitution, and **are not subject to the caveats provided for in the existing regulations, including that the condition poses a public health threat**.

42. In order to survive constitutional challenge, it must be shown that the infringement contained in Regulation 15H is:

> "reasonable and justifiable in an open and democratic society based on human dignity, equality, and freedom, taking into account all the relevant factors, including the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and the purpose, and less restrictive means to achieve the purpose" (Limitations clause, section 36 Constitution).

43. It is submitted that constitutionality cannot be determined in a blanket manner for all 50 different conditions to which this provision is apparently intended to apply.

44. However, it is further submitted that none of the conditions listed in Tables 1 to 4, nor Covid-19, warrant the near total negation of the right to bodily integrity provided for in regulation 15A, and all can be adequately managed with less restrictive measures as already exist.

45. In fact, we argue that such coercive restrictive measures actually undermine public health goals.

5.2. Undermines public health in practice

46. During the HIV/AIDS epidemic, it was debated whether HIV/AIDS should become a notifiable condition. It was argued strongly and convincingly that this would have a negative effect on public health *inter alia* **because it would discourage people from seeking help**, due to stigma of the disease and the consequences of contact tracing and other consequences of notifiable conditions for patients.

47. To this day HIV/AIDS has, correctly in our view, remained off the notifiable conditions list and is now a disease successfully managed with (truly) voluntary testing, counselling and treatment.

48. There is evidence that lockdown coercive provisions in relation to Covid-19 may have undermined public health by discouraging people from receiving a diagnosis and therefore from receiving care.

49. It can be theorised that because of stringent requirements of isolation, contact-tracing, rules against visiting in public hospitals and the like which were applicable to a Covid-19 diagnosis, people may have chosen not to seek medical attention in order to avoid a Covid-19 diagnosis, and its associated implications which were prescribed by law.

50. This possibility is strongly suggested by comparing the number of official Covid-19 deaths recorded in hospitals (100 000)[11] and the number of excess deaths estimated by the SAMRC (300 000).[12]

51. This suggests that some 200 000 people who were sick enough to die chose rather to die at home than seek medical care during the height of the Covid-19 pandemic. In other words, twice as many people died outside of places where they could receive a diagnosis as died in places where they could.

52. This is also suggested by the large discrepancy between the number of official Covid-19 diagnoses (approximately 3.7 million, 6 April 2022)[13] and the number of infections suggested by antibody testing (approximately 71 percent of the population, or 42 million people, November 2021) and the IFR (referred to in paragraph 6 above) (possibly the whole population).

53. In other words, 10 times as many people did not get an official diagnosis as did.

54. This also points to the relative pointlessness of using official Covid-19 diagnoses as a real measure of the extent and progression of the disease, which is one of the justifications for making conditions notifiable i.e., that it enables disease tracking.

55. Wastewater analyses provides a far more accurate warning system than official diagnoses.[14]

56. **Any provision which discourages people from seeking medical care for Covid-19 undermines public health**, because medical care does boost survival rates, as often it is the case that simply providing oxygen over a key period of infection can allow a patient to recover, in the case of Covid-19 in particular.

57. The Western Cape had the smallest differential between hospital-recorded deaths and excess deaths (65% of deaths were recorded, compared to the average of 32% for the country)[15] and accordingly had an age-standardised death rate which was three-quarters of that of the rest of the country average (387 per 100 000 versus 511 per 100 000)[16]. This strongly suggests that a higher rate of accessing medical care boosted survival rates.

58. **As soon as it becomes known that a diagnosis of a notifiable medical condition can lead to involuntary isolation (which is a form of deprivation of liberty) not only of oneself, but also of one's family and friends with whom one has been in contact, there will be a strong disincentive for people to seek medical care, drastically undermining public health.**

[11] 'COVID-19 Update on Covid-19 (Wednesday 06 April 2022)', 6 April 2022, https://sacoronavirus.co.za/2022/04/06/update-on-covid-19-wednesday-06-april-2022/.
[12] 'South African Medical Research Council - Report on Weekly Deaths in South Africa'.
[13] 'National Institute for Communicable Diseases', accessed 3 April 2022, https://gis.nicd.ac.za/portal/apps/opsdashboard/index.html#/6564559bcf32429ca29ccbd290d094dd.
[14] 'South African Medical Research Council - SARS Cov-2 Wastewater Surveillance Dashboard', accessed 5 April 2022, https://www.samrc.ac.za/wbe/.
[15] Moultrie et al., 'Correlation of Excess Natural Deaths with Other Measures of the COVID-19 Pandemic in South Africa'.
[16] https://www.samrc.ac.za/reports/report-weekly-deaths-south-africa

59. **Indeed, the mere publishing of these draft regulations has likely already seriously undermined public health, as has the last two years of similar provisions applicable under the State of Disaster.**

60. Regulations 15B to 15H relate to 15H. While 15B refers to the need to obtain a court order to force isolation or quarantine where a person refuses, existing regulation 20 creates an offence for any refusal to comply, which will also apply to such a refusal. Unlike the existing provisions, there is no caveat of public health threat or requirement for counselling.

61. Regulation 15G provides for completely unrealistic criteria for self-quarantine and self-isolation for the South African context, with the result that only the most well-off will be able to do so. This has implications for equality.

62. Contact tracing, as provided for in Regulation 15H, has proven to be impossible for Covid-19, particularly since the Omicron variant. Even in relation to TB, it remains difficult and expensive in the South African context. It should remain abandoned for Covid-19.

63. Time and resources spent on contact-tracing could be better spent on providing care for ill people.

5.3. Deprivation of liberty under 15F

64. South Africa is a party to the UN Convention against Torture since 1998 and in 2019 ratified the Optional Protocol to the Convention against Torture (OPCAT). The compulsory deprivation of liberty by means of quarantine facilities, as proposed in Regulation 15F, raises a number of concerns.

65. The first is that provinces have a limited mandate (see for example Child and Youth Care Centres)[17] and municipalities no mandate, to establish and operate places where people are deprived of their liberty, as seems to be envisaged in the proposed regulation.

66. Secondly, such quarantine facilities would meet the definition of "deprivation of liberty" as set out in Article 2 of OPCAT. From this would then flow a series of obligations under international and domestic law, which South Africa is already only in partial compliance with regard to existing places of deprivation of liberty.

67. Thirdly, the National Preventive Mechanism (NPM) under OPCAT must therefore be enabled to monitor such facilitates and the UN Sub-committee on the Prevention of Torture (SPT) will also have, like the NPM, unrestricted and unannounced access to all persons, places and documents concerning such quarantine facilities.[18]

68. It is thus unlikely that the provisions under Regulation 15F would survive judicial review.

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[17] 'Constitution of the Republic of South Africa' (1996), pt. 4A.

[18] 'OHCHR - Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', 2002, sec. 11, https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel.

6. Proposed regulations 16A – 16K

69. These regulations go beyond the operation of the Health System and seek to impose obligations on persons, businesses and institutions in their day-to-day lives. It is submitted the Minister is making regulations beyond the intended scope of the envisaged regulation-making powers of the empowering legislation.

70. These provisions will constitute a limitation on business and prevent economic recovery. Job losses are already a key problem for South Africa and **any measure which exacerbates job losses while providing no clear benefit should be avoided**. The table below shows the worsening situation in relation to jobs, which closely affects poverty. This is directly attributable to restrictions on economic activity imposed by the State of Disaster.

71. *Table 1: Working age population employment, March 2020 and December 2021*

Population	March 2020	December 2021
Population 15-64	38 874 000	39 888 000
Employed	16 383 000	14 544 000
Not employed	22 491 000	25 344 000

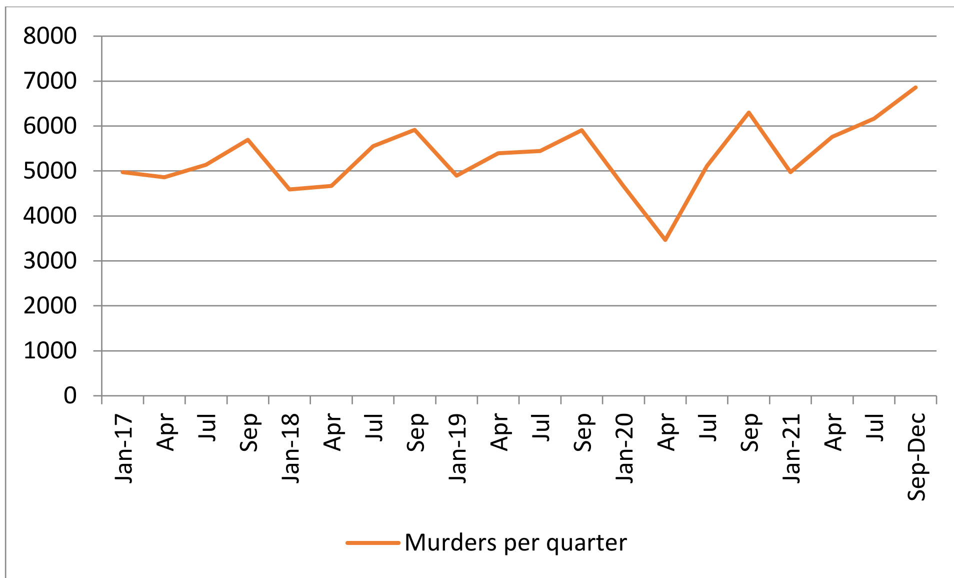
72. Recent data collected in 2021 shows that one quarter of children aged 5 years old had significant stunting caused by long-term malnutrition. [19] Reports have also emerged of more children dying of malnutrition than previously. There needs to be an appreciation that **measures which harm the economy and result in job losses which deepen poverty have public health consequences**.

73. These consequences include a worsening of violent crime, which in turn places an additional burden on the criminal justice system, as well as constituting another form of public health harm, through loss of life via murder and the physical and psychological harm of violent crime.

74. It is quite clear that the two years of restrictions have led to conditions which have resulted in an unprecedented number of murders per quarter, our most reliable indicator of trends in relation to violence. In the quarter to December 2019 there were 5918 murders. In 2021 over the same period this had increased to 6859, an increase of 16%.

[19] S Giese 'The Thrive by Five Index — measuring what matters most for our children' *Daily Maverick* 11 April 2022 available at < https://www.dailymaverick.co.za/article/2022-04-11-the-thrive-by-five-index-measuring-what-matters-most-for-our-children> [accessed 12 April 2022].

75. Table 2: Murders recorded per quarter, South Africa



Source: SAPS Crime data collated [20]

76. Any measure which continues to stand in the way of the resumption of economic activity will contribute to the worsening of the situation in relation to poverty and violent crime.

6.1. Proposed regulation 16A(1-4)

77. Regulation 16A provides for mask-wearing in public indoor spaces and on public transport in perpetuity.

78. Mandatory mask wearing is an infringement of the right to freedom and security of the person, via the right to bodily integrity, which includes the right to security in and control over one's own body.

79. This infringement may in certain circumstances be justified in terms of the limitations clause discussed in paragraph 4 above.

80. However, a permanent limitation of this nature is unlikely to be constitutional. It is clearly unjustified when the risk of infection of any disease is low, as it has been over a number of time periods over the last two years, and when natural immunity has been built. Such a measure simply cannot be justified on a permanent basis.

81. Furthermore, permanently requiring such a measure leads to decreased compliance and therefore reduced utility, where such utility exists.

82. Furthermore, the provision will condemn children to wearing masks in schools forever.

[20] 'South African Police Services - Crime Statistics: Integrity', accessed 2 April 2022, https://www.saps.gov.za/services/crimestats.php.

83. The Constitution provides that the "best interests of the child" are paramount in every matter concerning the child in terms of section 28(2) of the Bill of Rights. It is not in the interests of children that they and their teachers wear masks in perpetuity.

84. Masks increase difficulty of listening[21] and interfere with speech understanding.[22] Consequently it is obvious that masks are an impediment to children's education, particularly those children who are learning in a first additional language and not their mother tongue, or who have hearing or other disabilities. Hearing impaired individuals are also reliant on lipreading and non-verbal facial expression cues in order to communicate effectively. This is not possible with masks unless of a transparent variety.[23]

85. Children are themselves at extremely low risk of serious illness from the virus[24], while teachers and parents have had ample opportunity to be vaccinated and boosted.

86. It is now understood that Covid-19 is likely to be airborne[25] rather than only droplet-driven. Thus, the utility of poorly-fitting cloth masks come into question, even if primarily used as a measure to prevent persons with an infection from infecting others.

87. Furthermore, mask-wearing has become politicised. The result is that evidence of the utility of masks during the Covid-19 pandemic has been largely observational in nature and frequently does not make use of proper control groups.

88. The only properly randomised control-trial which existed pre-pandemic (and is therefore not politicised), found in relation to influenza, that while surgical masks had some utility, cloth masks actually increased the likelihood of infection among health-care workers wearing them in Vietnam, despite strict washing protocols.[26]

89. It is possible that something like this result may have occurred in South Africa, where most people frequently re-use and re-wear their cloth masks, and wear them incorrectly or when moist, which would be likely to raise their own risk of infection.

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[21] E Giovanelli et al., 'Unmasking the Difficulty of Listening to Talkers With Masks: Lessons from the COVID-19 Pandemic', *Sage Journals* 12, no. 2 (10 March 2021): 1–11, https://journals.sagepub.com/doi/full/10.1177/2041669521998393.

[22] R So¨nnichsen et al., 'How Face Masks Interfere With Speech Understanding of Normal-Hearing Individuals: Vision Makes the Difference' 43, no. 3 (March 2022): 282–88, https://journals.lww.com/otology-neurotology/Fulltext/2022/03000/How_Face_Masks_Interfere_With_Speech_Understanding.4.aspx.

[23] Sharaf Sheik-Ali, Shirwa Sheik-Ali, and Azizi Sheik-Ali, 'Hearing Impairment and Introduction of Mandatory Face Masks', *Ear, Nose & Throat Journal*, 22 February 2021, 0145561321992514, https://doi.org/10.1177/0145561321992514.

[24] C Smith et al., 'Deaths in Children and Young People in England Following SARS-CoV-2 Infection during the First Pandemic Year: A National Study Using Linked Mandatory Child Death Reporting Data', *Research Square*, 7 July 2021, https://www.researchsquare.com/article/rs-689684/v1.

[25] T Greenhalgh et al., 'Ten Scientific Reasons in Support of Airborne Transmission of SARS-CoV-2', *The Lancet* 397, no. 10285 (1 May 2021): 1603–5, https://www.thelancet.com/article/S0140-6736(21)00869-2/fulltext#articleInformation.

[26] CR MacIntyre et al., 'A Cluster Randomised Trial of Cloth Masks Compared with Medical Masks in Healthcare Workers', *National Library of Medicine* 5, no. 4 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/.

90. Our exceptionally high excess mortality rate of 531 per 100 000 thus far suggests South Africa has fared worse than most countries despite two years of mask-mandates.

91. Well-fitting surgical masks should be worn in high-risk contexts or with vulnerable populations, such as oncology treatment centres or in hospitals. People should be empowered to understand when this is necessary, and proper surgical masks should be provided in these contexts.

92. Masks should no longer otherwise be required in schools or any other place.

6.2. Proposed regulation 16A(5)-(7)

93. Provisions on social distancing in the workplace provided for in these provisions no longer make sense for the current stage of the epidemic. They act as an additional cost to business and brake on productivity.

94. Recall that non-compliance has a severe criminal penalty. This cannot in any way be justified.

6.3. Proposed regulation 16B

95. This regulation proposes that persons exiting South Africa are required to have a vaccination certificate.

96. This infringes both the right to bodily integrity and the right to freedom of movement contained in section 21(2) of the Bill of Rights of the Constitution, which provides that everyone has the right to leave the Republic.

97. Vaccination does not markedly prevent infection nor transmission.[27] Its major utility is in preventing serious illness and death of the vaccinated person. Accordingly, it will be difficult to justify this provision in terms of the limitations clause.

98. Given the porousness of our land borders, this provision is likely only to apply in practice to wealthier air travellers, such as businesspersons and tourists, and constitute another bureaucratic hurdle preventing trade and tourism, and deepening joblessness and poverty.

99. Unvaccinated tourists will not visit if they are compelled to be vaccinated before they leave.

6.4. Proposed regulation 16C

100. This regulation proposes either a negative PCR or a vaccination certificate to enter the country. Neither measure will prevent an infected person from entering the country. Furthermore, if an additional infected person enters the country, it will make little difference given that the vast majority of people (more than 70 %) have already been exposed to the virus.

[27] C Stokel-Walker, 'What Do We Know about Covid Vaccines and Preventing Transmission?', *The BMJ* 376 (4 February 2022), https://www.bmj.com/content/376/bmj.o298.

101. The provision simply acts as an impediment to the full resumption of tourism, which in turn affects jobs, which in turn affects poverty, which in turn affects crime. Countries which rely on tourism significantly have tended to abandon these provisions.

6.5. Proposed regulations 16D-16G

102. These provisions suffer from the same problems as those relating to 15B and 16C, in providing low utility restrictions to cross-border interactions.

6.6. Proposed regulations 16H-16K

103. These provisions restricting economic activity via restrictions on places and gatherings should only be enacted while a public health threat is in fact present (i.e., during periods of high transmission of a new disease for which there is little immunity. They should not be permanently in place. The restrictions on gatherings in 16H in particular impede our economic recovery and are in no way justified.

104. Police holding cells[28] and prisons are commonly accepted as vectors of disease. The focus in the regulations on hand sanitisers and masks in the proposed regulations, seems misplaced when large numbers of people move annually through police holding cells that generally fall short of standards for humane and hygienic detention. The awaiting trial prisons pose similar risks and even the Minister of Justice and Constitutional Development has admitted that social distancing is not possible in prisons.[29]

7. Proposed amendment to regulation 17

105. This provides for compelled treatment, prophylaxis etc. by warrant order of court, notwithstanding rights to legal representation in existing regulation 17. It appears that the intention here is to permit a warrant to be issued in the absence of legal representation, again an unjustifiable limitation.

[28] SA Human Rights Commission, ‘The Conditions and Treatment of People in Police Custody in South Africa - Report on Visits to Police Stations by Independent Custody Visitors 2019-2020’ (Johannesburg: SA Human Rights Commission, 2021).

[29] Parliamentary Communication Service, ‘It Is Impractical to Practise Social Distancing in Correctional Centres - Committees Hear’, *Parliament of South Africa* (blog), 29 April 2020, https://www.parliament.gov.za/press-releases/it-impractical-practise-social-distancing-correctional-centres-committees-hear.

8. Conclusion

106. Existing provisions of the regulations to the Public Health Act are sufficient and appropriate in the South African context for the management of notifiable conditions. The proposed amendments should be rejected in their entirety.

107. South Africa should focus on rebuilding trust in and improving of the health system response, rather than on controlling public behaviour, in attempting to control something which no longer poses a significant threat.

108. Deaths due to poverty, violence and other diseases and conditions which have been less well managed over the last two years due to the focus on Covid-19 are now posing more of a risk than Covid-19.

109. Inappropriately using the criminal justice system, which is itself struggling to build trust, to enforce public health interventions of likely limited utility, is the worst way forward.

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