WHO and national responses to COVID-19 have been ‘fear driven’ — Prof Wood

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The **World Health Organisation** (WHO) and most countries failed to take to heart crucial historical lessons of global influenza pandemics and botched timeous travel shutdowns, as well as the protection of vulnerable populations, said Professor Robin Wood at the fifth **PPS** Webinar this week. Instead, similar to the four major and more serious past flu pandemics stretching back to 1919, their responses were were fear driven, with politicians cherry-picking data from exaggerated predictive models of infection and mortality.

Prof Wood, CEO of the D**esmond Tutu Health Foundation** and member of the **University of Cape Town**’s Institute for Infectious Disease and Molecular Medicine, said the associated cost in lives, poor health and poverty of the more “draconian” government interventions was unacceptably high, reports Chris Bateman for ***MedicalBrief***.

He cited **UNICEF** figures showing that 40-60% of children were being severely impacted by COVID-19 restrictions through less access to healthcare, joblessness and reduced education opportunities. Tuberculosis, the major cause of infectious disease deaths in South Africa, is a treatable condition that causes approximately 200 deaths per day in South Africa however, numbers testing at our TB clinics have halved during the Covid-19 lockdown.

Prof Wood was addressing 600 medical professionals on “historical precedent – the need for perspective” in the fifth of a highly successful webinar series, hosted by health professions indemnity company, PPS, *Medical Brief* and UCT’s Desmond Tutu Health Foundation.

He said the data do not support official concern about young people becoming infected with Covid-19, (hard-hit **New York** recorded just nine deaths of people under 19), while the comparable youth mortality rate per million people was “infinitesimally small.”

“The youth have no more problems with COVID-19 than with normal influenza. Despite lack of personal risk, lockdown rules have been put into place in order to ensure they don’t infect the elderly and vulnerable. Yet, globally little effort has been made to protect the, elderly and those with co-morbidities properly,” he stressed.

“How much cost can we put on young people when we don’t have the proper strategies to protect the elderly?”

Globally, fear-driven strategies seemed to be aimed at stopping or mitigating the pandemic while failing to look after vulnerable people. In spite of robust lockdowns, the virus has persisted and spread, which is particularly true in the **Western** and **Eastern Cape** provinces.

He cited resurgences of Covid-19 in **Australia** and **New Zealand** where they effectively shut down hard and early, adding that once the virus became endemic (without herd immunity); “as soon as you ease up, it takes off again.”

Prof Wood stressed the importance of asymptomatic carriage of the virus, saying this made isolation and quarantine strategies much more difficult.

“As soon as the numbers increase, the need for resources becomes massive. New Zealand, Australia and **South Korea** did really well, and **Japan** currently looks like a classic second wave, though we don’t really know. We need to have enough humility to say we don’t know,” he added.

He downplayed the chances of a second wave of infections in South Africa, while emphasising that scientific knowledge on immunity was thin. Any second wave would be “determined by the immune status of the population and the cross reactivity other COVID-19 related diseases.”

The Western Cape had experienced a very fast infection upswing and a slow decline, moving down to a seven-day average similar to less-affected provinces.

“One could postulate that those provinces with the highest rates would be less likely to have a second wave. Differences in case-load between provinces and countries do not appear related only to timing and intensity of non-pharmaceutical interventions” he added.

Asked whether the South African lockdown achieved what it set out to do, Prof Woodsaid adherence with lockdown was demonstrated by mobility indices which indicated similar declines in values as the UK, with public transport use dropping by 80% and retail trade and workplace attendance by 50%.

As in the tragic 1918 “Spanish Flu” contagion which caused 50 million deaths world-wide, fear-based, self-imposed isolation and quarantine (similar to contemporary official lockdown), had more impact on decreasing the peak infection rates but less on overall mortality.

“I’m convinced the official predictive models were overly pessimistic. Initial lockdown enabled health facility preparation to avoiding overwhelming of the health system. The Western Cape; it was as badly affected UK, Italy and Spain however they didn’t have to use the extra capacity created during the lockdown. In retrospect, it was not as bad as predicted, however going forward we must balance the benefits of quite draconian interventions with the harmful consequences, especially for young people,” he said.

The fear of children taking the disease to adults was real, but recent headlines like a COVID-19 outbreak at a local boarding school causing children to be sent home illustrated just how counterproductive such knee-jerk reactions could be.

“If it were influenza, you wouldn’t have had the same reaction,” he commented.

Examples of more ‘step-wise’ approach to mitigation measures included the more intelligent use of South Africa’s dramatically increased testing capacity and reducing quarantine times from two weeks to three days, followed by a test.

“We need a more subtle response than condemning people to poverty and withdrawing them from normal healthcare,” he added.

Among the WHO *faux pas* was the delay in declaring the pandemic, declaring it a new virus with no immunity, flip-flopping after saying masks were dangerous, and labelling asymptomatic infections as unimportant.

However, his biggest beef with the WHO was their saying C-19 was not aerosolised, but ‘large particle spattered,” a statement that resulted in aerosol scientists writing an open letter of disagreement. The resultant WHO advice was that the N95 mask use be restricted to health-care workers involved in aerosol producing procedures that incidentally have never been shown to produce aerosols. The rubbishing of the concept of ‘immunity passports,” might need to be walked back at a future date. “I think immunity testing might allow us to open up our industries and travel industries“ he added.

The authoritarian response of South Africa brought to mind the quote; ‘A crisis is the rallying cry of the tyrant,” justifying non-scientific and freedom-curtailing policies. “I couldn’t understand why surfers swimming alone in the waves were being arrested”.

Prof Wood said the post-World War I pandemic, in an outbreak that became known as Black October killed three percent of South Africa’s population in just six weeks, mainly because soldiers returning from the West Coast of Africa were put in “desultory quarantine” and criss-crossed the country by rail. Many people had died from bacterial pneumonia in addition to the effects of the virus. In the absence of antibiotics and a vaccine, the epidemic was largely curtailed through acquisition of herd immunity.

The 1957 **Asian** pandemic went unnoticed in **China** until reported by the ***New York Times***. It was about 10 times worse than the normal average annual flu epidemic, though nowhere near as severe as the 1918 pandemic, with between just one and four million deaths globally. The **Hong Kong** epidemic of 1968 killed about one million people, mainly over 65 and subsequently became a cause of seasonal influenza. It was imported to the **USA** from **SE Asia** by

returning **Vietnam** troops and the spread to **Europe** caused 50% of **France**'s workforce to be bed-bound.

The 2009 HIN1 pandemic frightened everybody as it was initially compared to the 1918 HIN1 pandemic, but it turned out to be more of a "technical pandemic", with similar morbidity and mortality as a typical annual influenza outbreak. By comparison to the infection and morbidity of these earlier pandemics, COVID-19 in South Africa to date has resulted in 600,000 cases and 13,000 officially recorded deaths.

Prof Wood said **SA Medical Research Council** has estimated the excess mortality during this pandemic to be 36,000 deaths, almost threefold higher than the 13, 000 officially recorded deaths. Mortality estimates for South Africa stand at between 200 to 600 deaths per million population, with marked provincial variation.

COVID-19 estimates for South Africa stood at between 200 to 600 deaths per million population, with dramatic provincial variations. Another example of official overestimation was the **United Kingdom** where the public perception of COVID-19 infections and deaths, as opposed to the reality, has been overstated by a factor of 100.

Fifth PPS Webinar on YouTube
The webinar series

The PPS Webinar series drew on the infectious diseases research and expertise of Professor Robin Wood. Launch on 19 June, the series drew the participation of more than 3,000 attendees. The detailed reports have been accessed by more than 10,000 readers.

Here is information about the previous four webinars, including links to them for those who are interested. Embedded with in the articles are links to the full **YouTube** videos:

SA is over the COVID-19 hump; time for a new, provincial strategy — Prof Robin Wood
Data indicates that South Africa has passed the peak of the COVID-19 infections wave, says Professor Robin Wood of the University of Cape Town. Despite its limitations, pandemic modelling suggests SA should now move from a single national response to more nuanced provincial responses.

COVID-19 transmission – The global misuse of data
Decisions on COVID-19 made by governments and the World Health Organization may literally be life-or-death and yet political leaders have made avoidable errors and misused 'scientific data', respected medical scientist Professor Robin Wood told a PPS Webinar. The bungling regarding the airborne transmission of the coronavirus is an example.

Fast and dangerous — The road to a COVID-19 vaccine

There is a great deal to worry about in the race for a COVID-19 vaccine, said leading medical scientist Professor Robin Wood. Challenges include the rapid pace of development, the need to avoid health-threatening mistakes, the huge amounts of money involved and immense pressure to thwart the deadly virus, he told a webinar hosted by PPS Health Professions Indemnity, MedicalBrief and the Desmond Tutu Health Foundation.

COVID focus must stress prevention and good, early treatment

Professor Robin Wood, one of South Africa's eminent medical scientists, says that while Western medicine tends to focus on the sickest patients, to make a public health impact efforts need to concentrate on stopping people getting COVID-19and on providing good, early treatment to prevent disease progression. In the first of five PPS webinars drawing on global research to inform local prevention and treatment, Wood also said he was no longer sure what South Africa's overall strategy was in responding to the pandemic.