

Position Paper on Travel to South Africa

Executive Summary:

The coronavirus situation in South Africa is well managed. Case numbers are low and have remained stable for over two months, with no sign of a third wave. Since the beginning of the pandemic, the government of South Africa has acted proactively and responsibly, and continually followed a science-led approach to managing the pandemic. Current 28-day averages of COVID-19 tests, daily cases and active cases do not justify for South Africa to be placed on any “red list” or no-fly list, as the relative risk of COVID-19 infection is very low, particularly for tourists. For more than two months, since the end of the second wave, South Africa has managed to keep case numbers low and stable, far below those of our key tourism source markets. Seroprevalence studies suggest that a significant percentage of South Africans have already been exposed to SARS-Cov2 and it is likely that over 50% of the population already have antibodies. This may explain South Africa’s success in defeating the second wave (in which the 501Y.V2 variant was dominant) without the help of vaccines. South Africa’s success story also argues persuasively against the widespread but unfounded fear over the 501Y.V2 variant first discovered here, which is the main concern driving the travel bans imposed against South Africa. Vaccines are effective against this variant, and the variant has not been linked to more severe disease or increased mortality. South Africa can confidently be declared as a safe destination to travel to.

Any Travel Health Notification system (US) or Traffic Light System (UK) that places South Africa in a red category or “do not travel” category, is demonstrably flawed and overly cautious in its approach. Any such system needs to be based on actual science and evidence, not on assumptions or inaccurate computer modeling, and the criteria used should balance the urgent need to reopen international travel and promote economic recovery with the ongoing need to prevent new waves of COVID-19 infection. This can only be done if a thorough cost-vs-benefit analysis is conducted to help guide the criteria being used to categorize countries or destinations.

Following below is a detailed and evidence-based justification for why South Africa should be declared as a safe destination to travel to.

Government approach

Since March 2020, South Africa’s government took early action and the first strict lockdown was announced on Sunday night 22 March 2020, when there were only 402 confirmed cases. A national state of disaster was declared and the newly formed National Coronavirus Command Council, advised by top scientists and medical experts, has since managed the national lockdown and public health response with a very responsible, science-based approach.

South Africa took a very cautious and conservative approach to international travel. All borders were closed with effect from midnight on 26 March 2020. All flights in and out of South Africa were cancelled, and all non-essential international travel and inter-provincial travel was banned. International borders were only reopened eight months later on 11 November 2020. At the moment, as of 10 May 2021, South Africa’s average new daily case numbers as well as active cases are much lower than they were on 11 November, when international borders reopened.

Professor Salim Abdool Karim, South Africa’s top epidemiologist who spearheaded the government’s response to the pandemic until his recent resignation, is world-renowned and was recently appointed to the WHO’s Science Council. Throughout this pandemic, South Africa’s response has been led by world-class scientists and epidemiologists, and has been praised by the WHO as a model for other countries to follow. Executive Director of the WHO’s Health Emergencies Program, Michael Ryan, referred to South Africa’s COVID-19 response as being “incredible” and among the best in the world.

In spite of the slow rollout of their nationwide vaccination campaign, South Africa’s overall response should inspire trust. The country cannot be accused of mismanaging or downplaying the pandemic. The statistics and reports coming out of South Africa are accurate and reflect a country committed to following the science, and dedicated to fighting this pandemic in the most effective and responsible manner.

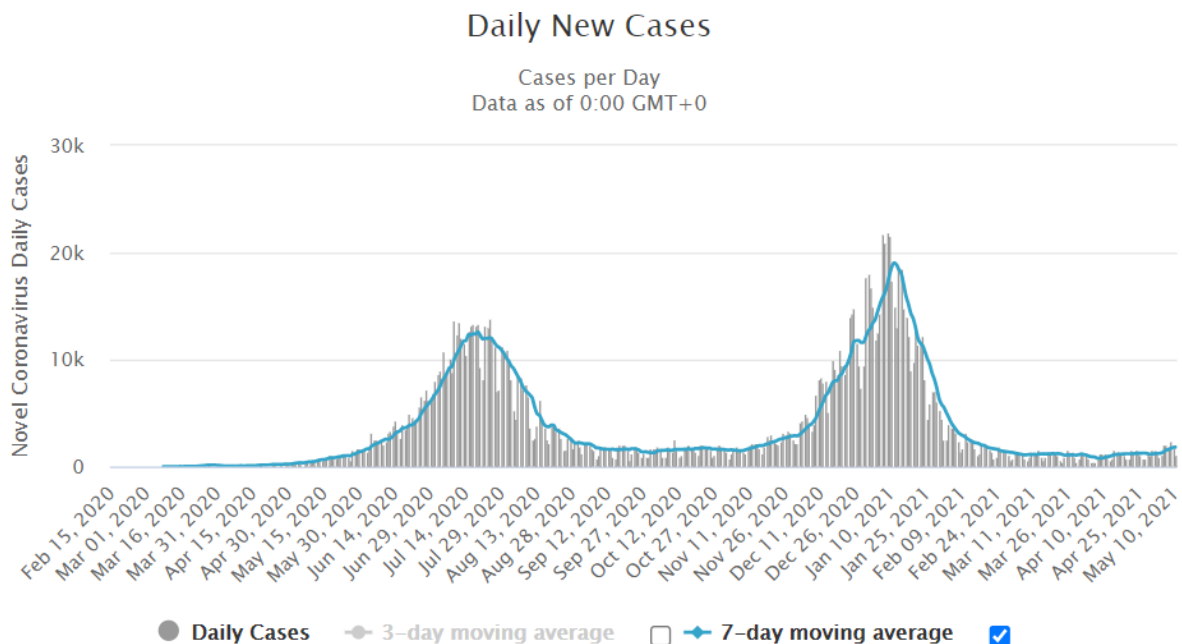
Pandemic trajectory

To see the COVID-19 situation in context, it is important to look at the pandemic trajectory and current case numbers, and compare them to the key source markets that have banned travel to and from South Africa.

South Africa has seen two distinct waves of infection. The first wave peaked in July 2020, and the second wave peaked in January 2021. Predictions and fears of a third wave following Easter have so far not materialized.

New Daily Cases:

Since mid March 2021, average new daily cases have remained stable on around 1,200 per day. Current 7 day rolling average is at 1,823 new cases per day, or 30 per million population:



(Source: <https://www.worldometers.info/coronavirus/country/south-africa/>)

Comparison to key source markets:

SA: Current 7 day rolling average is 1,823 new cases per day or 30 per million (10 May 2021)

UK: Current 7 day rolling average is 2,195 new cases per day or 32 per million (10 May 2021)

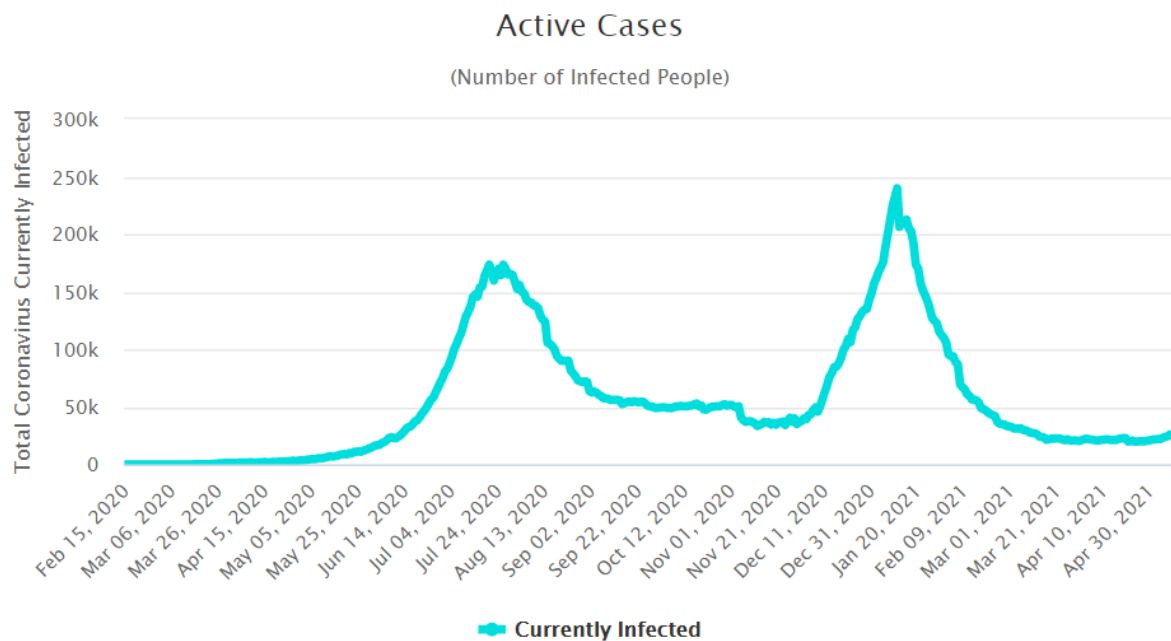
US: Current 7 day rolling average is 39,634 new cases per day or 119 per million (10 May 2021)

Germany: Current 7 day rolling average is 14,382 new cases per day or 171 per million (10 May 2021)

It is clear therefore that South Africa's 7 day average of new daily cases is much lower than that of key source markets that have banned travel to and from South Africa.

Active Cases:

Active cases in South Africa have remained below 30,000 since early March 2021. Current active cases make up about 0.043% of the population, or 426 per million population:



(Source: <https://www.worldometers.info/coronavirus/country/south-africa/>)

Comparison to key source markets:

SA: Currently 25,549 active cases or 426 per million (10 May 2021)

UK: Currently 58,909 active cases or 866 per million (10 May 2021)

US: Currently 6,411,702 active cases or 19,312 per million (10 May 2021)

Germany: Currently 274,273 active cases or 3,265 per million (10 May 2021)

It is clear therefore that South Africa's active cases are orders of magnitude lower than that of key source markets that have banned travel to and from South Africa. Based on this metric alone, there is no justification for travel bans to and from South Africa, as the risk of infection is miniscule compared to these source markets.

CDC COVID-19 Travel Health Notices

South Africa has been placed on Level 4 of the CDC’s COVID-19 Travel Health Notices, which purports to assess the level of COVID-19 threat for different destinations.

Level 4 reads: “Very high level of COVID-19. Travelers should avoid all travel to these destinations.”

This assessment is completely incongruent with the actual level of COVID-19 present in South Africa, as outlined above, especially in comparison to the US itself and other important source markets. It also does not match the CDC’s own criteria, by which South Africa should be on Level 3.

Based on the criteria used by the CDC to determine the threat level for the COVID-19 Travel Health Notices, it is clear that South Africa meets the requirements to be on level 3, not level 4.

See <https://www.cdc.gov/coronavirus/2019-ncov/travelers/how-level-is-determined.html>

In the summary below it is important to note that South Africa has been hovering near 1200 in terms of number of tests conducted per 100k population over 28 days (CDC wants this to be above 1200, even for countries with a low prevalence of COVID-19 like South Africa).

The number of new cases over 28 days in South Africa is currently at 64 cases per 100k population.

COVID Statistics South Africa				(official stats from sacoronavirus.co.za)							
	Daily	28 Day Total	28 Day Average	Daily	28 Day Total	28 Day Average	28 Day Average	Current	Active Cases	Active Cases	
Date	Tests Done	Tests Done	Tests per 100k	New Cases	New Cases	Cases per 100k	Test to Case Ratio	Active Cases	% of population	Per 100k pop	
28-Apr-21	22514	710759	1184.60	1250	30294	50.49	23.46	20554	0.034	34.26	
29-Apr-21	23137	701171	1168.62	1086	30086	50.14	23.31	20779	0.035	34.63	
30-Apr-21	29840	703389	1172.32	1674	30487	50.81	23.07	21240	0.035	35.40	
01-May-21	27957	714955	1191.59	1632	31342	52.24	22.81	21704	0.036	36.17	
02-May-21	16194	719032	1198.39	1222	32101	53.50	22.40	21869	0.036	36.45	
03-May-21	16752	724693	1207.82	897	32546	54.24	22.27	21986	0.037	36.64	
04-May-21	24040	732596	1220.99	1187	33296	55.49	22.00	21981	0.037	36.64	
05-May-21	33414	741416	1235.69	2073	34613	57.69	21.42	23279	0.039	38.80	
06-May-21	32577	738119	1230.20	2149	35396	58.99	20.85	23845	0.040	39.74	
07-May-21	25934	733493	1222.49	2256	36385	60.64	20.16	24737	0.041	41.23	
08-May-21	29873	733902	1223.17	2191	37291	62.15	19.68	26005	0.043	43.34	
09-May-21	26098	736987	1228.31	1778	38138	63.56	19.32	25604	0.043	42.67	
10-May-21	18311	739256	1232.09	1129	38612	64.35	19.15	25549	0.043	42.58	

(Source: <https://sacoronavirus.co.za/> - table compiled by Onne Vegter)

The test-to-case ratio is between 10 and 30 (the CDC ideally wants this to be above 30, even for countries with a low prevalence of COVID-19 like South Africa).

What is also important to note is that the US itself, along with Canada, the UK and most of Europe are facing much bigger challenges than South Africa at the moment, and are all on Level 4 (avoid all travel). The CDC has failed to issue a Travel Health Notice against the US itself, which is currently experiencing over 400 new cases per 100k population over 28 days.

This overly cautious approach to international travel is not in line with the WHO’s advice on international travel, and is not congruent with the scientific studies showing that international travel presents a very low risk of infection (estimated to be 1 case per 27 million passengers). See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7655026/>

The WHO has published considerations for a risk based approach to international travel in the context of COVID-19. See <https://www.who.int/publications/i/item/WHO-2019-nCoV-Risk-based-international-travel-2020.1>

One of the considerations put forward by the WHO is the economic impact of ongoing international travel bans. In a country like South Africa, which relies heavily on tourism and where tourism directly

accounts for 8.7% of GDP and supports 1.5 million jobs, the economic impact of international travel bans or “do not travel” advisories by source markets is devastating.

Apart from a clear instruction to consider the economic impact in designing a risk based international travel strategy, the WHO also recommends asking this question, to help assess the relative level of risk: “How likely are travellers to be infected in the country of destination compared to their likelihood of getting infected in the country of departure?”

Based on the current case numbers, the answer to this question is of key importance to South Africa, because it is clear that most travellers will be *much safer* in South Africa and *much less likely to be infected* than back in their home country. Combined with stringent infection control measures and other risk mitigation protocols such as symptom screening, mandatory masks and the requirement of presenting a negative PCR test before boarding, makes the CDC’s current Travel Health Notice for South Africa not just completely inappropriate and unnecessary, but absurd.

We should also not lose sight of the fact that the overall response to this pandemic has departed significantly from pre-COVID recommendations by the WHO on the use of NPI’s during a pandemic.

Note that before this pandemic, Entry and Exit Screening as well as Border Closures were “Not recommended in any circumstances” by the WHO.

Table 1. Recommendations on the use of NPIs by severity level

SEVERITY	PANDEMIC ^a	EPIDEMIC
Any	Hand hygiene Respiratory etiquette Face masks for symptomatic individuals Surface and object cleaning Increased ventilation Isolation of sick individuals Travel advice	Hand hygiene Respiratory etiquette Face masks for symptomatic individuals Surface and object cleaning Increased ventilation Isolation of sick individuals Travel advice
Moderate	<i>As above, plus</i> Avoiding crowding	<i>As above, plus</i> Avoiding crowding
High	<i>As above, plus</i> Face masks for public School measures and closures	<i>As above, plus</i> Face masks for public School measures and closures
Extraordinary	<i>As above, plus</i> Workplace measures and closures Internal travel restrictions	<i>As above, plus</i> Workplace measures and closures
Not recommended in any circumstances	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Border closure	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Internal travel restrictions Border closure

NPI: non-pharmaceutical intervention; UV: ultraviolet.

(Source: <https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf>)

Variants of concern

The circulation of several “variants of concern” and the media-hyped fear surrounding the so-called “South African variant” has been central to the travel bans that have been imposed upon South Africa since the discovery of the 501Y.V2 variant (also known as the B.1.351). South Africa’s testing, surveillance and genetic sequencing capacity is world-class, and allowed the country to identify and describe the 501Y.V2 variant in late 2020. Whether this new variant originated in South Africa or elsewhere is not known (it occurs in more than 50 countries) but since the announcement of the discovery of this variant, the tendency for this variant to be described as the “South African variant” in the news media has stigmatized South Africa as a destination. The presence of this variant remains the main reason why so many countries have banned travellers from South Africa and put South Africa on a no-fly list. It is sad and ironic that South Africa’s scientific excellence has inadvertently become the cause of an ongoing campaign of fear, discrimination and marginalization.

It is clear from the literature and from South Africa’s experience that the 501Y.V2 variant is not more dangerous than the original SARS-Cov2. It appears to be approximately 1.5 times more contagious, according to the scientific literature, but it does not lead to more severe disease or higher mortality. South Africa’s experience during their second wave in December 2020 and January 2021 (during which the 501Y.V2 variant was dominant) indicates that mild, less restrictive NPIs such as masks, hand washing, social distancing and avoiding large crowds are effective in stopping this variant and bringing R below one.

During South Africa’s second wave, borders remained open, travel was allowed (and it should be noted that domestic travel as well as gatherings of family and friends were common during this time, due to the summer holiday period), higher risk establishments such as gyms, hairdressers, restaurants, shopping malls as well as non-essential stores and markets all remained open (but had visitor capacity capped to 50%), and 16-seater commuter taxis operated at full capacity. South Africa’s housing situation is such that a large percentage of the population (in densely populated townships and informal settlements) is unable to lock down effectively. Curiously, beaches, rivers and parks and other outside areas in nature were closed by the government in an effort to limit outdoor holiday crowds, which resulted in more people gathering indoors at malls and restaurants. Despite such a nonsensical restriction on outdoor spaces, and without the benefit of vaccines, the second wave was brought under control swiftly, R dropped below one, and case numbers have subsequently remained low and stable since February 2021. South Africa’s success should give the world plenty of encouragement that the 501Y.V2 variant is NOT a variant to be very concerned about. It can be easily controlled through standard non-pharmaceutical interventions. The presence of this variant does NOT justify travel bans or travel advisories with South Africa’s current low case numbers.

One particular fear regarding new variants is whether existing vaccines will be effective. To date, the available data show that the vaccines are effective, although some smaller studies suggest a lower level of efficacy.

Encouragingly, Pfizer and BioNTech announced on 1 April 2021 that their vaccine appeared to be 100% effective in stopping the South African variant in a group of 800 volunteers from South Africa who participated in a Phase III trial. The overall efficacy was estimated to be 91%.

See <https://www.medpagetoday.com/infectiousdisease/covid19vaccine/91895>

Subsequently, a very small Israeli research paper based on real world data raised the question of possible vaccine “breakthrough” which resulted in widespread headlines on various media platforms saying the “South African variant” can “break through” the Pfizer vaccine, whipping up more fear around this variant. In reality, the study found only eight people who tested positive with the South African variant in spite of being vaccinated. Importantly, in an update to the study posted on April 16, which the media completely failed to report on, the researchers noted that within the group of people who received two doses, which comprised eight people, all eight of the B.1.351 infections occurred within a week to 13 days after the second shot. *None of them tested positive for it 14 days or more after the second dose.* That confirms Pfizer’s own data that their vaccine is indeed effective against the 501Y.V2 variant.

See <https://www.reuters.com/world/middle-east/south-african-variant-may-break-through-pfizer-vaccine-protection-vaccine-highly-2021-04-18/>

In a Twitter thread linked to below, Dr Monica Gandhi links to a number of studies that indicate why we should not worry about “variants of concern” escaping immunity from vaccines and natural infection.

See <https://threadreaderapp.com/thread/1379294379391676417.html>

It is clear from the studies referenced by Dr Gandhi that the alleged risk from “variants of concern” has been blown entirely out of proportion. The United Kingdom provides another clear real world example of that. The B.1.1.7 variant which has been dominant in the UK during their third wave which peaked in early January, has not prevented the success of their vaccination campaign. Through a combination of vaccines and NPIs the UK has managed to bring R below one, and has seen a 96% reduction in new cases since the peak in early January. This illustrates clearly that the vaccines used in the UK are effective against the B.1.1.7 variant.

The “Variants of Concern” (VOC) narrative has been used to stir up unnecessary fear, stigmatize certain destinations (their countries of first discovery), and justify unnecessary travel bans or travel advisories which continue to harm tourism and hamper international travel recovery, which is critical to the economic recovery of many countries, including South Africa and its neighbours in the SADC region. The hype and fear surrounding so-called Variants of Concern is not based on science. “We don’t know enough” is no longer an acceptable excuse for imposing or maintaining damaging travel sanctions which cause massive economic devastation as well as other very costly collateral damage. More on that below.

Economic impact of travel bans

South Africa relies heavily on tourism. In 2019, an estimated \$33 billion USD (9,4% of South Africa’s GDP) was generated directly by the tourism sector, and this excludes indirect benefits on supporting industries (construction industry, motor industry, banking sector, *et cetera*). Tourism sustains approximately 1.5 million jobs in South Africa, and it is estimated that at least 12 million people (20% of the population) are supported directly or indirectly by tourism.

The travel bans imposed by several countries on travel to and from South Africa, based on fears surrounding the 501Y.V2 variant, have had a devastating impact on South Africa’s tourism industry and cost more than 300,000 job losses already. Ongoing travel bans will accelerate the destruction

of this sector, as many businesses are hanging on by a thread and face imminent liquidation unless international inbound tourism recovers quickly. It is critical to note that poverty costs lives, and the drastic increase in poverty during this pandemic may well cause higher mortality in the long run than the mortality caused by COVID-19. Travel bans and travel advisories do real and lasting harm. A proper cost-benefit analysis of ongoing travel restrictions is critical to ensure that such measures do not cause more deaths than they prevent.

In addition, international travel and tourism supports conservation and anti-poaching efforts, not only in Africa but around the world. Africa in particular is heavily dependent on tourism revenue and conservation levies to support ongoing conservation work, the sustainability of protected areas, and anti-poaching efforts. The pandemic has had a devastating impact already on eco-tourism revenue, and ongoing travel restrictions bring the very real risk of lasting ecological damage and habitat loss. Many species of endangered wildlife are already under severe pressure, and the despair brought by the absence of tourism revenue is driving higher levels of poaching in many communities, and putting pressure on the custodians of land to switch from conservation and eco-tourism use to agriculture, mining and other more profitable land uses.

Limiting international travel is therefore not merely a public health decision, with medical or public health consequences. It carries a huge socio-economic cost. Please consider very carefully the impact of ongoing travel restrictions on countries like South Africa which depend heavily on tourism revenue to sustain jobs as well as conservation efforts.

South Africa's Vaccination Campaign

South Africa appears to be lagging behind many other countries in its vaccination campaign. Budget constraints and procurement hurdles have slowed South Africa's vaccine rollout plans. Currently, around 400,000 people in South Africa have been vaccinated as part of Phase 1 of South Africa's Vaccine Rollout Plan which is aimed at frontline health workers as first priority. Phase 2 is set to start on 17 May 2021 and will include essential workers, including frontline tourism staff and retail staff who are likely to have contact with travelers. Phase 2 will also include citizens over 60 years of age. While the vaccination drive is proceeding at a slower pace than we would have liked, we take encouragement from the low current prevalence of COVID-19 in South Africa (current active cases make up only about 0.043% of the population), as well as the robust Travel Industry Protocols which are in place to minimize the risk of infection (more on that below).

Vaccine inequality is a reality that should not lead to discrimination against countries or destinations that have limited access to sufficient vaccine doses. It is sad but true that wealthy western nations have been able to secure priority access to COVID-19 vaccines, and currently have a surplus of vaccines. A policy of shunning destinations that are slower in their vaccine rollout and have limited or delayed access to vaccines is immoral and discriminatory, and in fact may reduce public trust in vaccines. If countries like the US and UK have already vaccinated most of their vulnerable populations, and if travelers themselves are vaccinated, on what basis should such vaccinated travelers be warned against travel to a country like South Africa, where there are lower levels of vaccination but also much lower levels of COVID-19 prevalence? That would suggest that the vaccines cannot be trusted to work, and yet they have been shown to work. While the US and UK have a massive surplus of vaccines, many poor countries are not poised to see widespread vaccine access until 2022. See <https://www.eiu.com/n/85-poor-countries-will-not-have-access-to-coronavirus-vaccines/>.

Slow vaccine rollout or delayed access to vaccines should not be a reason for imposing travel restrictions to that destination, particularly if the overall prevalence and threat level of COVID-19 is low.

Seroprevalence

While South Africa may not have high levels of vaccination yet, it does appear to have high levels of natural immunity due to prior exposure to SARS-Cov2. Seroprevalence studies by the South African Blood Service in several provinces (based on results from 4858 donors from diverse demographics) found seroprevalence of antibodies to be as high as 63% (with higher prevalence noted in black donors compared to white donors). This may help to explain South Africa's success in defeating the second wave without the help of vaccines, and the absence of any spike in cases after Easter. South Africa may well be approaching an encouraging level of natural herd immunity. The WHO caused some controversy when it changed the definition of herd immunity in June 2020 (removing reference to naturally acquired immunity from previous infection and now referring only to vaccine induced immunity). It remains established science that recovery from infection contributes to population immunity, and studies have shown that those who have recovered from COVID-19 and have antibodies are at low risk of future infection, and that immunological memory (igG, memory B cells and T cells) persists for many months after infection.

See <https://www.nih.gov/news-events/news-releases/nih-study-finds-people-sars-cov-2-antibodies-may-have-low-risk-future-infection>

And <https://www.biorxiv.org/content/10.1101/2020.11.15.383323v1>

Travel Industry Protocols

In partnership with the Tourism Business Council of South Africa (TBCSA), an industry umbrella body representing most of South Africa's biggest tourism associations, leaders from all sectors of South Africa's tourism industry came together early on in the pandemic to develop a world-class set of travel industry protocols that are aligned with the WTTC's Global Protocols for safe travel. In addition, SAPOA and RASA have created robust protocols and guidelines for the safe reopening and operation of the restaurant industry. Globally, IATA has taken early initiative to ensure the safe reopening of air travel.

Combined, these protocols have so far proven very effective in mitigating the risk of infection during travel. While a few isolated global cases of infected individuals on international flights do exist (in all cases unvaccinated travelers who tested negative before departure), the screening protocols upon arrival have allowed authorities to identify and quarantine such passengers, as well as any of their contacts. In all known cases, large community outbreaks were successfully prevented. Large community outbreaks are overwhelmingly caused by local transmission, not by international travelers. No evidence exists of significant new waves of infection caused by an infected traveler.

This brings us back to the WHO's all important question when considering travel restrictions or advisories: "How likely are travellers to be infected in the country of destination compared to their likelihood of getting infected in the country of departure?" In the case of South Africa as a destination, the clear answer is "very unlikely". This is especially true for vaccinated travelers.

South Africa is safe. Tourism ground operations at all stages of a traveler's journey are conducted with the utmost care and safety protocols in mind. Public mask wearing, hand washing and sanitizing, social distancing, symptom screening and regular sanitizing of shared spaces and surfaces (fomites) are standard protocol. Limits on indoor venues and vehicle capacity as well as adjusted procedures for travel, meals and accommodation ensure the ongoing safety of travelers, and minimize the risk of infection. In addition, all international travelers are required to present a negative PCR test before boarding, at departure and upon return. By and large, international travelers will be individuals who are not symptomatic, have tested negative for COVID-19, and have been fully vaccinated. In this context, it makes no sense to have ongoing travel bans or travel warnings in place.

The full set of TBCSA protocols can be accessed here: <https://tbcsa.travel/covid-19-protocols/>

Conclusion

The existing travel warnings against South Africa are causing severe ongoing harm to the local economy, tourism jobs, conservation efforts and tourism recovery efforts. And such travel warnings are not necessary. South Africa's case numbers are orders of magnitude lower than those of key source markets that have warned against all travel to and from South Africa. The prevalence and risk of COVID-19 in South Africa is very low, and the current situation does not justify a "high risk" travel treat assessment, or a "do not travel" warning notice. An overly cautious public health response, in the absence of an objective cost-benefit analysis, is almost certain to do more harm than good. The current harsh travel warnings against South Africa are discriminatory, unjustified and completely disproportionate to the actual level of risk posed by international travel to and from South Africa, or by the 501Y.V2 variant which is dominant in South Africa.

We call on our source markets to review the literature linked to above, consider the rationale for opening travel to South Africa, and remove unnecessary travel restrictions, advisories or warnings that may harm South Africa's tourism recovery, while the threat level remains low.

We also call on the CDC to review its criteria for assigning Travel Health Notice levels, as they currently appear to be arbitrary and overly cautious. A zero risk environment never existed before and is not a realistic expectation for international travel as we begin to reopen after this terrible pandemic. Even with South Africa's low case numbers, adequate testing and surveillance, and world class tourism safety protocols, the country fails to meet the requirements even for level 2 of the Travel Health Notice Levels. The CDC appears to have chosen arbitrary, highly conservative numbers for testing and cases per 100,000 citizens. To our knowledge, no scientific study exists to justify these arbitrary numbers. South Africa is currently hovering around 1200 tests per 100k population over 28 days, and around 64 cases per 100k population over 28 days, but its test-to-case ratio is somewhat below the desired ratio of 30 (it is currently at 20, which is perfectly fine for the current low prevalence level). These numbers put South Africa into level 3 (avoid all non-essential travel) by a tiny margin, which is not congruent with the low level of risk posed by travel to South Africa. South Africa is currently stuck on level 4 (avoid all travel) for no justifiable reason. The criteria should be adjusted to find a better balance between the risk-based public health priorities and the urgent need for economic recovery and resumption of international travel. International travel to South Africa can be conducted safely.