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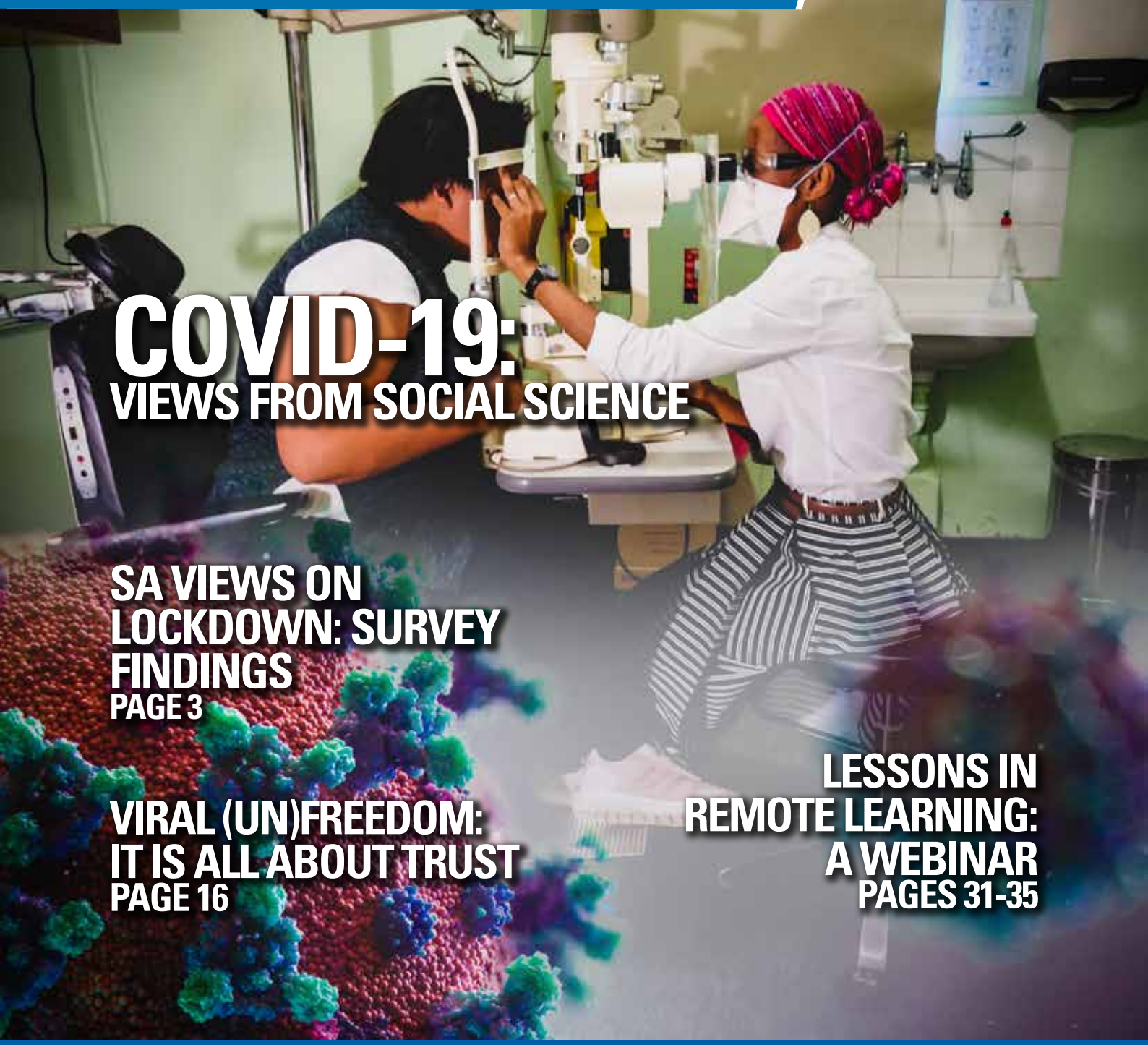

COVID-19: VIEWS FROM SOCIAL SCIENCE

HSRC
Human Sciences
Research Council

EDITOR'S NOTE

CONTENTS

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By the end of April 2020, South Africa was in the midst of a national lockdown to contain the spread of COVID-19, which has the potential to bring the South African health system to its knees.

The economy has already suffered an enormous blow.

In this edition of the *HSRC Review*, we feature a range of articles that highlight the extent to which this crisis may affect South Africans, especially the most vulnerable communities, and how it will bring poverty and inequality into focus.

The HSRC is helping the government with multiple surveys among citizens to record their understanding of the COVID-19 situation. These surveys will help the government to refine and target their COVID-19 messages and interventions. We have included a report on the results of the pilot survey, which looked at the public's understanding of COVID-19 and their response to some of the pandemic interventions.

Many of the lockdown challenges were predicted, hence the government's decision to deploy the SA Police Service (SAPS) and SA National Defence Force (SANDF) across the country to help enforcement. However, several incidences have been reported of alleged questionable interactions they have had with the public, such as humiliating or assaulting people in the streets and the killing of Collins Khosa in Alexandra, which is being investigated.

The danger is that such events can erode political trust, which is essential in a time of crisis, writes Prof Joleen Steyn Kotze in an article that looks at the potential effects of increased authoritarianism. Another article highlights the high levels of trust South Africans have had in the SANDF until now, according to the HSRC's South African Social Attitude Survey series. Adv Gary Pienaar looks at the question of human rights affected by the lockdown regulations and the need for democratic oversight.

Focusing on health, Dr Sizulu Moyo discusses TB in the context of COVID-19, highlighting potential areas of concern for South Africa and experiences from the TB response that could benefit and strengthen the country's response to the COVID-19 pandemic. Prof Narnia Bohler-Muller and Nokuthula Olorunju emphasise the need for strong collaboration between the private and public health-care sectors.

The COVID-19 pandemic will affect more than systems, resources and people's physical health. In South Africa, the stage is already set for major mental-health implications, writes Andrea Teagle in an article that focuses on the psychological impact of the crisis.

We also feature articles on food security and water provision, gender-based violence, remote teaching and the ban on alcohol sales.

Social scientists need to have their voices heard on a range of matters affecting South Africans over the next months.

At the time of writing this review, the HSRC had completed a second survey to look at how people have been affected by the lockdown, asking questions about people's living conditions, their ability to access food, water and health care, access to alcohol, their ability to earn an income, their interaction with law enforcement officers and their exposure to domestic abuse. The HSRC had also started a survey of health workers and another with Higher Health, formerly known as HEAIDS, on students' responses to the crisis.

We look forward to sharing the results with you in due course.

Antoinette

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Cover: *In March 2020, a week before the COVID-19 lockdown, ophthalmologist Dr Tshilidzi van der Lecq's husband Fritz shared a photograph of his wife wearing a medical mask at work. The way she described that scene some days later, reflected something that is at the heart of this pandemic, its effect on human relations: "Ophthalmology is an intimate speciality. It is second nature for us to sit close to our patients when we examine them, to touch their faces, and to communicate. COVID-19 has changed the way we interact with our patients. This picture was taken the first time I examined a patient in the clinic once the pandemic became a reality for us in South Africa. I was fearful and my hands were trembling. This is what happens when one human being cares for another. Emotions naturally arise and become part of the interaction. The fight is not only against the virus, but also in preserving our ability to still relate to our patients."*

VIEWS OF SOUTH AFRICANS DURING EARLY LOCKDOWN: AN HSRC PILOT STUDY

South Africa's strategy to contain COVID-19 relies on the public's willingness to adhere to the requirements of the lockdown and their understanding of messages around COVID-19 risk factors. The HSRC has been running several surveys to measure the public's understanding of COVID-19 and their response to some of the pandemic interventions. *Prof Priscilla Reddy* and *Antoinette Oosthuizen* report on the results of the pilot study.

Effective communication and community engagement are important aspects of South Africa's early and continued response to the COVID-19 pandemic. To this end, the World Health Organization (WHO) has provided technical guidance, but it cautioned that the elements of this guidance may differ between countries, depending on their risk levels, capacity and people's perceptions and needs.

South Africa has a unique history of inequality, which means that its interventions and communication strategies need to target a heterogeneous population with vastly different health, socioeconomic, educational and sociocultural priorities. The country is burdened with other communicable and non-communicable diseases, such as tuberculosis and HIV-related conditions, hypertension, diabetes, obesity and heart conditions, all of which potentially put them at an increased risk of the more severe COVID-19. Social problems, such as substance abuse and high levels of violence both at community and interpersonal levels, especially gender-based violence, contribute to potential instability in some communities, a situation that may put the most vulnerable people, like women and children, at higher risk.

The country's apartheid legacy of spatial inequality puts many people at risk of infection due to the nature of their crowded living conditions and poor access to services. In many high-density settlements, several people share scanty informal dwellings. To access almost every basic need, such as clean water, sanitation, food and health care, they are exposed to crowded conditions, be it in queues at water points and clinics or on minibus taxis that serve as the main pillar of the public transport system. The areas where they live are often far from employment hubs, contributing to these communities being disproportionally affected by unemployment and poverty.

The authorities need to accurately adapt and target their messaging as the challenges of the pandemic change over time and to avoid message fatigue. This is why all communities' understanding and responses to COVID-19 need to be monitored early on and throughout the pandemic.

The HSRC pilot study

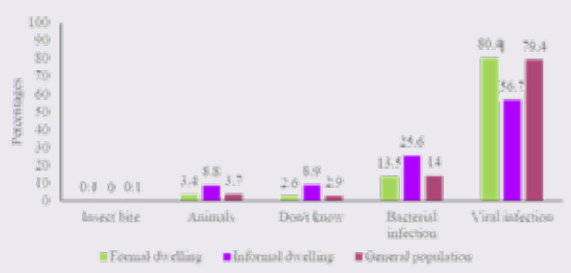
To support such monitoring, the HSRC ran an online survey in the first week of the lockdown (27 March to 2 April 2020). The data was benchmarked to the distribution of the South African population. A total of 55 823 people participated over the 7-day period for which the survey was operational. After benchmarking, 78% of the sample were black Africans and more than half were in full-time employment. A particularly important aspect of the project was the analysis of responses from 602 participants who reported that they lived in informal dwellings that were categorised as shacks and traditional hut dwellings. The intention was to support an understanding of possible communication and intervention needs in vulnerable communities.

Good knowledge of COVID-19

Generally, the findings showed that South Africans had a good understanding of the cause, incubation, transmission, symptoms and prevention of COVID-19, but there were some knowledge gaps.

Of those living in informal dwellings, 25% thought the disease was caused by a bacterial infection, 8.9% did not know the cause and 8.8% thought it was caused by animals. (Figure 1)

Figure 1: Knowledge about the cause of COVID-19



The vast majority of respondents knew that the incubation period for the virus was 2 – 14 days and that it could be transmitted through contact with an infected person and contaminated surfaces, but those who lived in informal dwellings were less likely (67.4%) to identify the risk of contaminated surfaces than those who lived in formal dwellings (85.8%).

Most people identified the symptoms (cough, fever and shortness of breath), but only half (51.6%) of those in formal and 29.7% of those in informal dwellings were able to identify body pain as a symptom.

> “A TOTAL OF 55 823 PEOPLE PARTICIPATED OVER THE 7-DAY PERIOD FOR WHICH THE SURVEY WAS OPERATIONAL.”

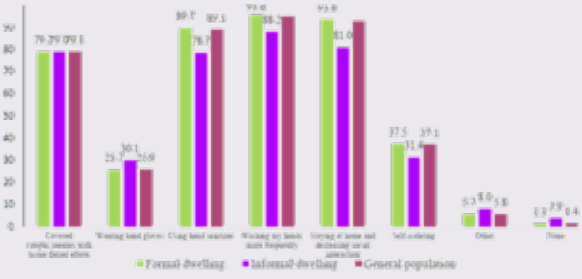
These findings present an opportunity to refine and target some COVID-19 messages.

Adopting preventative behaviour

The findings indicated a high uptake of preventative messages, especially regarding handwashing.

Among all residents, 95.2% indicated that they had washed their hands more frequently than usual, 92.9% reported staying home and limiting their social interactions, 89.1% had used hand sanitiser, and 79.1% had covered their coughs and sneezes. Of those living in informal dwellings, 88.2% reported frequent handwashing, 81% reported staying home and socialising less and they were equally likely to report that they were covering their coughs and sneezes. (Figure 2)

Figure 2: Strategies adopted to prevent COVID-19 infection

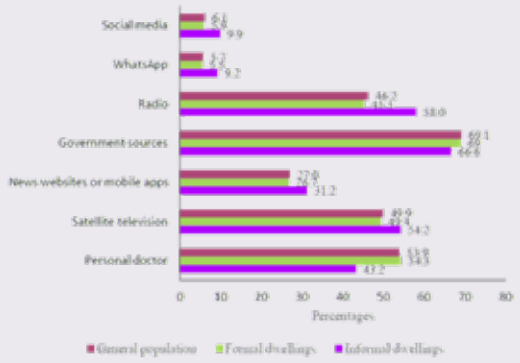


A minority of respondents reported self-isolating (less than 40%), possibly in line with the early stage of the pandemic in the country at the time of the survey and the understanding of concepts such as isolation and quarantine to relate to those with symptoms only. The reported wearing of gloves was also low, between 25% (formal) and 30% (informal), possibly due to it having been discouraged in some prevention communication due to feared supply shortages for health and other essential workers on the frontline. The researchers recommended clearer guidance, but in the interim, the government has clarified its recommendations to encourage South Africans to wear cloth masks.

Trust

More than two-thirds of respondents reported high trust in government information sources on COVID-19 (see Figure 3). Among those living in informal dwellings, the trust in government information sources (67%) was higher than their trust in radio sources (58%), satellite television sources (54.2%), and even their doctor (43.2%).

Figure 3: Main sources of trusted information on COVID-19

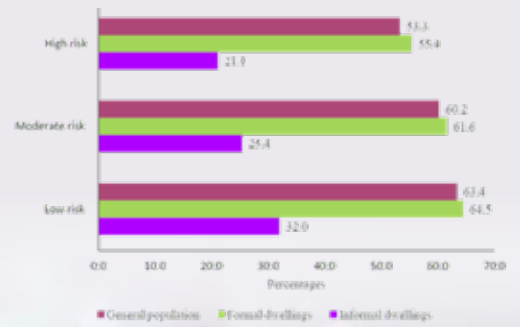


The respondents living in informal dwellings also had a stronger belief in the National Government's ability to manage the COVID-19 outbreak with 56.9% having a positive attitude compared to 47.7% of those living in formal dwellings. More respondents from informal dwellings (55.4%) also felt that the South African health system was capable of managing the COVID-19 outbreak compared to 40% in formal dwellings.

A spatial challenge?

When specifically asked about isolation in the case of someone showing symptoms, more than half (55.4%) of residents in formal dwellings who perceived themselves at high risk of getting COVID-19 indicated that they had a separate space in which to self-isolate or quarantine themselves. Only a fifth (21.1%) of self-perceived high-risk residents in informal dwellings reported that they had such a space. (Figure 4)

Figure 4: Availability of a separate space in the house for isolation or quarantine by self-perceived risk of contracting



This may be related to spatial challenges in such communities, where having a bedroom to oneself is regarded as a luxury by many. This indicates a need for innovative and practical methods of infection prevention to be developed for unique living conditions, ideally in collaboration with communities that understand their own spatial challenges best.

Risk perception

Overall, fewer than a quarter of survey respondents perceived themselves as having a high to very high risk of contracting COVID-19, 36.7% as having a moderate risk and 38.1% as having a low to very low risk. A very high-risk perception was almost twice as high among residents from informal dwellings (19.2%) when compared with those from formal dwellings (10.7%).

Residents were asked what they believed would most likely happen over the following month concerning COVID-19. Among those who perceived themselves as having a high risk of contracting COVID-19, about half — 56% of those living in formal and 49% of those in informal dwellings — believed that the worst was yet to come and things would get worse. This was an indication that the respondents took the danger of COVID-19 seriously. Despite their trust in government interventions, many expect a worsening scenario. This may point to a need for increased mental-health messaging and support services as a crucial component of South Africa's COVID-19 community-support strategy.

Going forward

At the time of writing, the HSRC had commenced a second survey to look at how people were affected by the lockdown, asking questions about people's living conditions, their ability to access food, water and health care, access to alcohol, their ability to earn an income, their interaction with law enforcement officers and their exposure to domestic abuse. The HSRC had also started a survey of health workers. The HSRC had also started a survey of health workers and another with Higher Health, formerly known as HEAIDS, on students' responses to the crisis.

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Projecting the likely **impact** of COVID-19 on food and nutrition security in South Africa

Major global outbreaks, including Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS), had a heavy impact on food and nutrition security in the affected countries. While the long-term effects on countries' food systems will depend largely on the unique course of COVID-19, this pandemic will be no exception. *Drs Admire Nyamwanza* and *Sikhulumile Sinyolo* explore the likely short- to medium-term impact of COVID-19 on food availability, access, utilisation and stability of supply in South Africa.

A major concern related to the escalation of pandemics, such as COVID-19, is whether food will remain available and accessible to all South Africans at prices they can afford, and whether this food will be nutritious and safe.

In the short- to medium-term, South Africa is unlikely to experience severe food availability challenges. Estimations from several institutions, including the Bureau for Food and Agricultural Policy, indicate that the country will have enough food for at least a year. For example, indications

A child receives food at an emergency school feeding programme in the Western Cape.

Photo: *Western Cape Government*

are that there will be a bumper harvest of maize, the staple diet for many, such that the country is poised to increase its maize exports to other countries. Good harvests are also expected for most domestically produced food crops, such as fruits. In addition, indications from global institutions, which include the Food and Agriculture Organisation, World Food Programme and the International Food Policy Research Institute, are that global food supplies are at comfortable levels. This suggests that South Africa should be able to access important food imports such as wheat and rice, barring massive disruptions in global supply chains. However, some countries have started putting restrictions on exports. These include Kazakhstan and Vietnam, which are key exporters of wheat and rice, respectively. Should this trend continue, and other countries also start restricting exports, there is a chance that there may be shortages in South Africa. There are no indications, as yet, that there would be shortages of highly perishable foods such as milk, fruit and vegetables in South Africa. However, disruptions in the supply chain due to restricted mobility are likely to increase food waste and loss, particularly of these perishables.

Food access

The main challenge in a highly unequal South Africa, even in non-crisis times, has been ensuring food availability and access at the household level, especially among marginalised communities in rural areas and informal settlements. The State of Food Security and Nutrition in the World 2019 report, for example, showed that, on the one hand, the country's food availability status, as measured by the food balances, was higher than the world average, but on the other hand, a third of the population (29.9%) experienced severe levels of food insecurity. The country performed significantly below the world average (8.7%) or even Africa (22.1%). According to the definition of 'severe food insecurity' (page 31 of the report), this means that almost one out of three South African households "have likely run out of food, experienced hunger and, at the most extreme, gone for days without eating, putting their health and well-being at grave risk", more than the average household in Africa. These figures suggest that, while food is largely available in South Africa, the challenge during the COVID-19 pandemic is in improving the logistical and resource means of poor households to access it.

As researchers from the Institute for Poverty, Land and Agrarian Studies argued in a recent article, the primary danger in South Africa in the context of COVID-19 is not necessarily that supermarkets will be empty, but that an increasing number of people will not be able to afford to buy from them. This is particularly so for households whose livelihoods have been put on hold by movement restrictions as has occurred during the lockdown, such as informal street traders and restaurant workers, who do not qualify for relief under existing relief measures. In rural areas, movement restrictions may interfere with farming activities, reducing potential yields for the year. Smallholders cannot afford to have reduced output, which could lead, in turn, to reduced potential income and increased food unavailability. Consequently, reduced incomes are likely to force these households to rely on cheaper and less preferred foods.

Food utilisation

Food utilisation focuses on how households use food through adequate diet, clean water, sanitation and health care to reach a state of nutritional wellbeing. There is currently no evidence to suggest that the coronavirus that causes COVID-19 is transmitted through food, and

Mosselbay Municipality helps to distribute food parcels to those in need.

Photo: *Western Cape Government*

Volunteers in Phillippi, Cape Town packing food parcels to be given out to the needy during the COVID-19 lockdown.

Photo: *Discott, Wikimedia Commons*

therefore, the negative impact of the disease vis-à-vis food utilisation will mostly be secondary. The first short-term implication for food utilisation will most likely be around an increase in unhealthy consumption patterns. As a result of the movement restriction and lockdown, there is likely, in the immediate term, to be an increase in preferences for more staple, non-perishable and ready-to-eat foods, which can easily be stored. Most of these foods are ultra-processed and generally of poor nutritional value. Secondly, with schools having closed earlier and with a possibility of remaining closed for some time, COVID-19 has also compromised the nutrition of many of the over nine million learners who currently benefit from the National School Nutrition Programme (NSNP) as their primary source of reliable and nutritious food.

With its far-reaching, devastating implications, the COVID-19 pandemic has led to heightened awareness of the need for good hygiene and sanitary practices, which are in turn linked to food safety. Personal hygiene practices that are being promoted at an accelerated pace, such as regular hand washing and the cleaning and disinfecting of surfaces, are likely to continue.

Food stability

The food stability dimension points to the fact that, to be food secure, people must have access to adequate food at all times and they should not be at risk of losing access to it due to sudden shocks or cyclical events. COVID-19 itself is a serious worldwide shock and it may be too early to make definitive conclusions on its potential ripple effects vis-à-vis the two main food stability factors related to such pandemics: disruption of the food supply chain and food price inflation. As far as the former is concerned, restrictions on movement, including that of farmworkers, may affect food production in the country. As Qu Dongyu, director-general of the Food and Agriculture Organization of the United Nations, warns, even when the situation begins to normalise, 'basic aversion behaviour' or the fear of contagion by workers, could, for a period, impede farming activities. Furthermore, food processing, which, in most cases, requires people to work in close proximity, may slow down, as social-distancing measures are likely to continue to be encouraged in South Africa, as in many other countries, for the foreseeable future.

Implications of the pandemic on food-price inflation in South Africa remains unclear in the immediate term. As Wandile Sihlobo, a chief economist of the Agricultural Business of South Africa wrote in a recent article, South Africa has adequate food supplies for 2020 and the 2020 food price inflation should remain at about 4% year-on-year. In the context of such pandemics as COVID-19, food price spikes are mostly caused, among other factors, by panic buying, which results in temporary food shortages as happened in China during the 2003 SARS outbreak. This seems not to be the case in South Africa (at least during the March-April 2020 period, at the time of the writing of this article). It is important to note, however, that stability of food supply in the context of this pandemic will effectively be dependent upon the intensity and reach of the spread of the disease and the success of various measures put in place to contain it.

Conclusion

There are still many unknowns regarding the progression and successful containment of COVID-19 in South Africa; however, proactive action by the government is needed to ensure and guarantee citizens' food and nutrition security in the context of this disease. We submit that the following three broad measures will be critical in the short- to medium-term: firstly, expanding focused social assistance and food relief to the most vulnerable e.g. the very poor, beneficiaries of the NSNP and the elderly, including encouraging the expansive involvement of non-governmental organisations in this regard. Secondly, continued close monitoring of food prices and consumer behaviour, especially in the context of restriction of movement measures. Lastly, ensuring the continued smooth logistical operation of agricultural and food supply chains.

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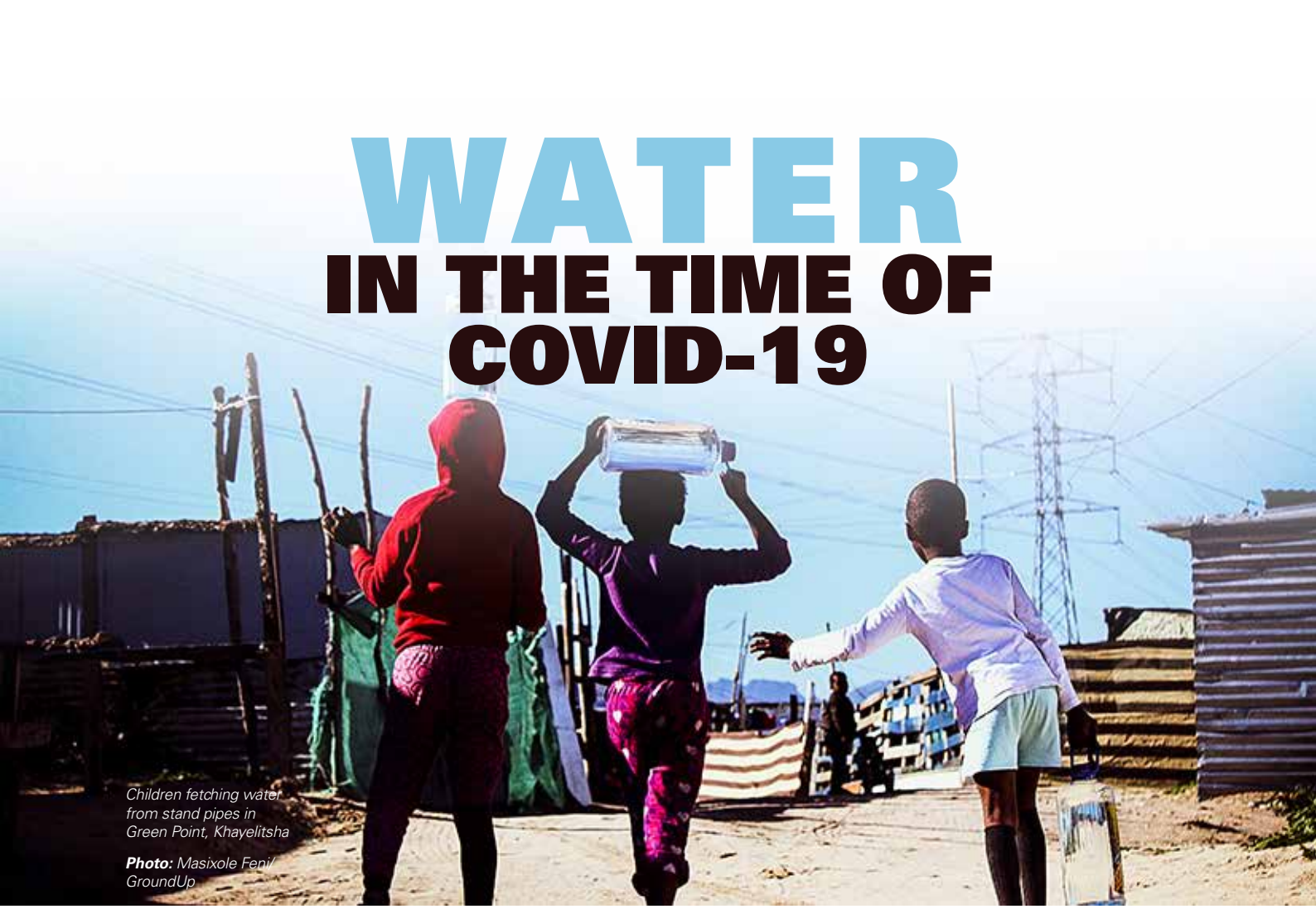
WATER IN THE TIME OF COVID-19



Children fetching water from stand pipes in Green Point, Khayelitsha

Photo: *Masixole Feni/ GroundUp*

The harsh socioeconomic realities faced by many South Africans on a daily basis are exacerbated during pandemics such as COVID-19. *Drs Michael Cosser* and *Kombi Sausi* examine the extent to which the right of access to water as an immutable socioeconomic right to be enjoyed in sickness and in health, has been realised.

Access to water as a basic socioeconomic right is enshrined in section 27(1)(b) of the South African Constitution, which states: "Everyone has the right to have access to ... sufficient food and water". Access to water, moreover, is a human right, that is monitored annually by the South African Human Rights Commission (SAHRC). However, the SAHRC has reported that this monitoring has been erratic, largely due to the failure of the Department of Water and Sanitation, the Department of Cooperative Governance and Traditional Affairs and the Department of Mineral Resources to respond to its annual requests for information. This has led to the SAHRC having to rely on data from Statistics South Africa (Stats SA) to report on.

Realisation of the right of access to water

Table 1 shows the extent of access to piped water (inside the dwelling, inside the yard, or at an access point outside the yard) among the general population in 2016, 21 years into democracy.

Table 1: Percentage of the population with access to piped water, 1996 vs. 2016, by province

Province	Census 1996	Community Survey (CS) 2016	% change, 1996-2016
Eastern Cape	62.4	75.1	20.4
Free State	95.7	96.2	0.5
Gauteng	97.5	97.5	0.0
KwaZulu-Natal	73.2	85.4	16.7
Limpopo	78.0	80.0	2.6
Mpumalanga	86.7	88.1	1.6
Northern Cape	96.6	94.3	-2.4
North West	86.2	86.1	-0.1
Western Cape	98.3	99.0	0.7
South Africa	84.5	89.9	6.4

Sources: Stats SA (1998); Stats SA (2016); authors' own calculations

Only two provinces — the Eastern Cape and KwaZulu-Natal — registered healthy increases (20.4 percentage points and 16.7 percentage points respectively) in the proportion of their population that had access to water by 2016 — but off a low base. A quarter of the population of the Eastern Cape and 15% of the population of KwaZulu-Natal still had no access to piped water in 2016. By 2018, the situation had worsened. Two provinces (Free State and Limpopo) saw reductions in access to piped water (calculations based on 2019 Stats SA data), while the percentage of South Africans as a whole who had access to piped water declined by 11 percentage points.

More poignantly still, only 46.3% of households in South Africa had access to piped water in their dwellings in 2018. Provincial statistics, which would have shown the extent of poor access to water in some under-resourced rural provinces, were not published.

Water in the time of a pandemic

The South African government, taking its lead from the World Health Organization, has published clear guidelines on the importance of washing hands with soap and water to guard against contracting the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes COVID-19. But if hand washing with soap and water is the primary precautionary measure against contracting the virus and 10% of the population has no access to piped water whatsoever, this leaves nearly six million people (Stats SA's 2019 mid-year population estimate was 58,775,022) particularly vulnerable to this viral infection. Many of these people live in densely populated, often water-scarce, areas, where there is understandably a fear of high levels of infection. This has important implications for household water management and the maintenance of hygiene – particularly given the need for uninterrupted water supply and strong supportive interventions during this pandemic.

This reality has not gone unattended. The Department of Human Settlements, Water and Sanitation (HSWS) has begun to deliver water-storage tanks and water tankers across the country. By 2 April 2020, a total of 612 water-storage tanks and 31 water tankers had been delivered to the Free State, 287 tanks to Gauteng, and 262 tanks and 27 tankers to Limpopo.

The media has reported on further water-related government plans. The Minster of HSWS has reportedly identified 2,000 communities nationally that are in need of water support, and by 28 March her department had procured 19,000 of the 41,000 water tanks, which it hoped to have installed before the end of March. The minister was reported as saying that the decision had been taken to "cut the long process of procurement" and go directly to the distributors and manufacturers. "We have been in touch with manufacturers who have said 400,000 tanks are available to procure."

The bypassing of onerous procurement procedures and the fact that the HSWS has been able to deliver water to communities that have either never had water or had only poor-quality water points to the cruel irony of service delivery at the time of a pandemic: what has taken years to achieve, and only partially at that, can be achieved when there is political will. But as Dr Jo Barnes, a retired epidemiologist, pointed out to the *Sunday Tribune*, water provision cannot be undertaken overnight, especially in the midst of a health crisis. Water reticulation systems take time to design and develop; what remains to be seen is whether the water authorities will undertake this in the wake of the COVID-19 pandemic.

The other irony of the government provision of water during the COVID-19 pandemic is that the water is intended for the washing of hands. Samuel Taylor Coleridge in *The rime of the ancient mariner* intoned:

> *Water, water, everywhere,*
>
> *And all the boards did shrink;*
>
> *Water, water, everywhere,*
>
> *Nor any drop to drink.*

Will there be water for the poor to drink once their hands have been washed? Will municipalities sustain free basic water provision beyond the current state of disaster?

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Aligning knowledge, skills and capabilities across South Africa's health-innovation system to combat COVID-19

Never before has the importance of alignment between key actors in the national system of innovation around shared development goals been more important than in the current global battle against COVID-19. By *Dr Glenda Kruss*

White textile mask on wooden table

Photo: *Anshu A, Unsplash*

Over the past weeks, one of the strengths in South Africa's approach to contain COVID-19 has been the rapid — and integrated — response of key actors in our health-innovation system.

South African scientists were very quickly able to contribute to the global effort to find a cure for the virus, by sequencing the genome of a local sample of severe acute respiratory syndrome coronavirus 2 (SARS-COV-2), the virus that causes COVID-19. A key public research institute, the Centre for Scientific and Industrial Research, established a national COVID-19 information centre to monitor and track the disease, to provide vital data to government. South African teams have been included in global innovation challenges designed to rapidly identify innovative solutions to the most critical problems emerging during the pandemic, including socioeconomic challenges.

K-Way Clothing Manufacturers in the Western Cape is making cloth masks to stop the spread of COVID-19.

Photo: *Western Cape Government*

Universities began to use their research resources such as 3D printers to produce protective face masks for health workers, and their IT expertise to create vital data dashboards and interactive apps with real-time data that support public information.

The South African Radio Astronomy Observatory, which had built up expertise to develop complex systems on the Square Kilometre Array project, was tasked to lead the national effort to design, produce and procure vital ventilators. To support this effort, businesses are unearthing blueprints for ventilators to resume production, or designing low-technology solutions with available resources, while Denel is converting its arms production capability. Textile companies in the once vibrant clothing sector in Cape Town are contributing their skills by manufacturing cloth face masks.

Medical practitioners in academic hospitals have designed equipment that protects health workers from contamination during life-saving procedures. Most significantly, there are indications that the resources and networks built over decades of experience in treating and managing HIV/AIDs and TB infections are informing the management and treatment protocols for COVID-19, not least in the design of a proactive mass community-based testing programme.

Health as an island of excellence in the national system of innovation

Such responses are only possible because of past efforts to build an effective health-innovation system, of which the key actors are described in *The state of the South African research enterprise*, a review released in 2019 by the DST-NRF Centre of Excellence in Scientometrics and Science, Technology and Innovation Policy (SciSTIP) at Stellenbosch University.

Indeed, South Africa was one of the first countries to foreground in its science and technology policy the idea that, to support economic growth and inclusive socioeconomic development, we need to build a strong national system of innovation. This includes actors in higher education, public and private research institutes, government, business and other intermediary organisations, each with different purposes and operating at different levels – but oriented to achieve shared national development goals. Success lies in the flows of knowledge, technologies and innovation between users and producers, which requires effective interaction, linkages and collaboration.

Unfortunately, over the past decade, the national system of innovation has not always functioned as effectively as it should have, with less collaboration and transfer of ideas and technology than desired. Such an assessment is reflected in attempts to redesign the science, technology and innovation (STI) landscape, and in the recent articulation of a new vision for STI, aligned with the national development plan and Sustainable Development Goals, set out in the White Paper on STI 2019.

Fortunately, there are 'islands of excellence' in the innovation system – and one of these is the health sector.

Excellence in health is focused on fields that support the current interventions against COVID-19, shaped by decades of responding to the burden of diseases in a highly unequal society with high levels of poverty and unemployment. The SciSTIP review analysed academic publications in health fields, finding that just over 70% focused on infectious diseases: 46,1% on HIV/AIDS and 25,8% on other infectious diseases (identified using key words like virus, infection outbreak, surveillance, and fever, for example).

A distinctive feature of the health-innovation systems is a number of 'mega-research' institutions, such as the Centre for the Aids Programme of Research in South Africa, and mothers2mothers, which rely greatly on international donor support. According to the SciSTIP review, these institutes and centres combine significant human resources and multiple lines of research, and they have operating budgets that are much larger than research institutions anywhere else in the South African research system.

Weaknesses identified in the health-innovation system are equally significant to the success of present efforts — that health monitoring, data and surveillance systems were not sufficiently developed nor integrated effectively, nor was there sufficient capacity in the field of medical devices, particularly in terms of collaboration between health researchers, practitioners and industry, stated the SciSTIP review.

Expenditure on health R&D growing steadily

The mega-research institutions funded by foreign donors are critical to the health-innovation system, but for the health-innovation system to flourish and overcome weaknesses in a sustainable manner, it is critical to consider whether there is sufficient domestic expenditure to support health research and development.

The latest available data reported by the HSRC's Centre for Science, Technology and Innovation Indicators reflect that in South Africa in 2017/18, 0.83% of the Gross Domestic Product (GDP) was spent on research and development (R&D), below the national target of 1.5%.

Health R&D applies to research fields that include Engineering Sciences, Biological Sciences, Medical and Health Sciences and Social Sciences. Figure 1 shows that over the past five years, a relatively high and steadily growing proportion of gross expenditure on R&D (GERD) was allocated to health R&D, reaching 22% in 2017/18 — a positive indicator.

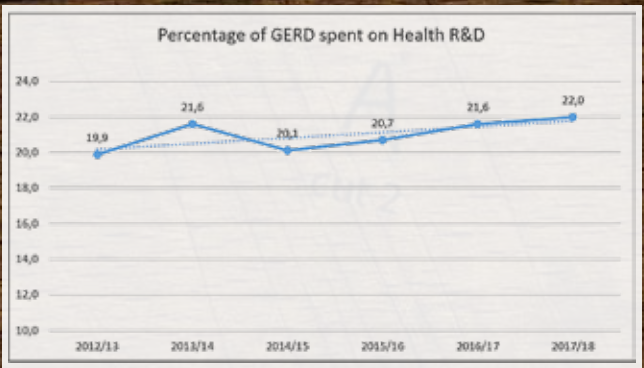

Figure 1. Percentage of GERD spent on Health R&D 2012/13 to 2017/18

Source: Centre for Science, Technology and Innovation Indicators

However, the question is whether these levels of expenditure are sustainable, given that the public sector is increasingly responsible for the majority of domestic health R&D expenditure. Figure 2 illustrates the growing share of the public sector in contrast to private expenditure, which includes the substantial health-oriented expenditure in the not-for-profit (NPO) sector. Historically, NPOs played a critical role in supporting HIV/AIDS research in the health-innovation system. Clearly, private-sector expenditure on health R&D could be substantially higher, to grow the system as a whole to the levels required to face the current challenges.

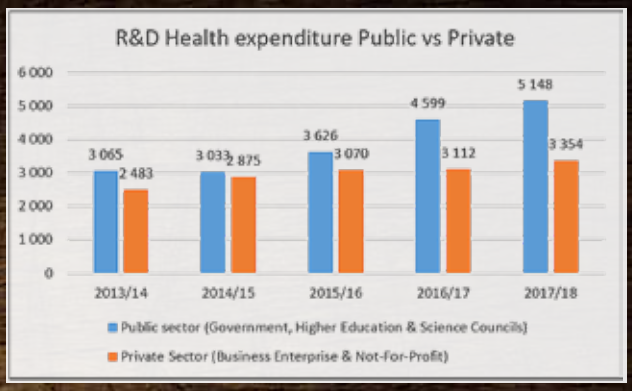

Figure 2. Public and private expenditure on health R&D 2012/14 to 2017/18

Aligning efforts across the health-innovation system

That the health-innovation system is an 'island of excellence', and that health R&D is oriented to the scourge of infectious diseases, is reflected in the ability of many actors to respond rapidly to the challenges of COVID-19.

However, for these initiatives to be effective over the long term, the data presented here suggest we need two kinds of policy intervention.

First, despite signs that the current levels of R&D expenditure are increasingly focused on health, South Africa should be spending far more on R&D in general, and on health specifically. There is, particularly, room for the private sector to contribute. Existing weaknesses in health data systems and design of medical devices require urgent increases in funding and effort.

Second, the COVID-19 pandemic presents an opportunity to strengthen the health-innovation system, which was more difficult to achieve in the past. That is, the strongly shared goal of different actors in the higher education, research, business and government systems — to control the impact of COVID-19 on lives and livelihoods — makes possible a high degree of coordination of effort. It is critical that as part of government efforts, a strategy should be devised to align the knowledge, skills and capabilities of medical practitioners, academic researchers, government agencies and firms across the health-innovation system.

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Acknowledgements
R&D data used in this article were prepared by Mario Clayford and Sibusiso Ziqubu; information on current initiatives was sourced by Gerard Ralphs.

TUBERCULOSIS in the context of the COVID-19 pandemic in South Africa

The day before COVID-19 lockdown in South Africa, a poster in a Cape Town pharmacy promoted TB awareness. World Tuberculosis (TB) Day, 24 March, fell in that same week.

Photo: *Andrea Teagle*

The COVID-19 pandemic reached South Africa in March - the month in which World Tuberculosis (TB) Day is commemorated. The 24th of March is dedicated to reflecting on the impact and advocating for the elimination of TB in individual countries and globally. *Dr Sizulu Moyo* discusses TB in the context of COVID-19, highlighting potential areas of concern for South Africa and experiences from the TB response that could benefit and strengthen the country's response to the pandemic.

TB has affected humans to varying degrees for millennia, with significant implications. In 1993, the World Health Organization (WHO) declared TB a global health emergency. In South Africa, approximately 301,000 people were diagnosed with TB in 2018, and it is the leading natural cause of death in the country. In contrast, the first case of COVID-19 was reported in December 2019, in China, and the disease was declared a pandemic on 11 March 2020. The first case of COVID-19 was reported in South Africa on 5 March 2020, and by 26 April more than 4300 people were confirmed positive with the virus and 86 had died from it.

Impact of COVID-19 and TB

Of note is that COVID-19 and pulmonary TB (the most common form of TB) both affect the respiratory system. Therefore, COVID-19 could be more severe in individuals who have TB, given their already existing lung pathology. Furthermore, people who have had TB in the past may be at greater risk of severe responses to COVID-19, with poorer outcomes, due to residual lung damage from the TB episode. Current knowledge suggests that people with undiagnosed and untreated TB are also at greater risk for severe responses to COVID-19. This risk could be further increased for those living with HIV who have low CD4 cell counts, although there is currently no published data on the co-occurrence of COVID-19 and TB, with or without HIV.

Impact on the health system

Information from China, Europe and North America shows that health systems rapidly become overstretched and are barely able to cope with the pandemic, once COVID-19 takes hold. This is a likely scenario for South Africa as the number of local transmissions increases. A strain on the health system would likely arise due to resource diversion to the COVID-19 response for contact tracing, screening, testing and treatment of cases that require hospitalisation. This could delay the diagnosis of those with TB and

increase interruption or treatment stoppage among patients already on treatment, with the consequence of reversing the previous gains made towards ending the TB epidemic in the country. The WHO and the STOP TB Partnership have called for efforts to be directed towards both conditions. The WHO is also releasing guidelines to help countries maintain essential health services for endemic conditions during the COVID-19 pandemic.

Lessons learned from the TB epidemic

Efforts to fight the TB epidemic in the country provide valuable lessons that can assist the response to COVID-19, and include the following:

1. **Working with community health-care workers to trace people diagnosed with COVID-19.** The TB programme has a well-established system of contact tracing for TB using community health-care workers, entry-level health-care workers who work directly with communities. The model of recruiting and training entry-level health-care workers is already being successfully applied to the COVID-19 response.
2. **Working with community volunteers and community health-care workers for raising community awareness and community education.** The TB programme works with volunteers who raise awareness about TB in a localised context. This model can be adopted to support the COVID-19 response in different areas across the country.
3. **Triaging of patients who attend health-care facilities.** Given the high burden of drug-resistant TB, triaging of individuals who might have TB is widely practised in many primary health-care facilities, which are often the first port of call for people with health problems and will, therefore, likely be the first port of call for many of those who might be infected with COVID-19. Although there is a need for strengthening the triaging process, it will not be a new practice for many health-care workers in primary health-care facilities. Additional measures that are specific to COVID-19 could, therefore, be implemented with minimal training and adaptation in many health-care facilities.
4. **Use of personal protective equipment:** The high burden of drug-resistant TB in the country has resulted in many health-care workers being aware of, and trained in, the proper use of N95 Respirator masks. TB programme staff can, therefore, be a resource for training other health-care workers on the correct fitting and usage of these masks.
5. **Communication and messaging:** TB prevention requires good cough hygiene, including coughing into a flexed elbow or a tissue, among other actions. Appropriate cough hygiene had, therefore, already been communicated widely in South Africa prior to the COVID-19 pandemic. However, anecdotal evidence suggests that individuals have not always adhered to this advice, suggesting a need for continuous and heightened messaging about COVID-19 prevention measures.
6. **Early adoption of new diagnostic technologies:** South Africa was one of the first high TB burden countries to adopt GeneXpert technology for the public sector to expedite the diagnosis of TB. This resulted in early diagnosis and initiation of treatment for many people with TB, and especially those with drug-resistant TB. The country should, therefore, be well prepared for the adoption of validated technologies to aid the COVID-19 response as soon as they are available.
7. **Dual testing of patients.** Given the overlap in symptoms, it will be important to test people with cough and fever for both COVID-19 and TB whenever this is indicated. The South African health system is experienced in implementing testing for TB and HIV co-infection and this experience can be applied to the COVID-19 epidemic in cases where co-infection is a possibility.

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Viral (UN)FREEDOM in the era of COVID-19: It is all about trust

Governments across the globe have taken drastic measures to contain COVID-19 through lockdowns, limiting physical contact between people, and tracking citizens through geo-tagging on their cellphones. What will the lasting effects be of increased authoritarianism? asks *Prof Joleen Steyn Kotze*.

Police minister, Bheki Cele visits the Winelands in the Western Cape.

***Photo:** SA Police Service*

Seen as the most urgent global health crisis since the 1918 Spanish Flu, governments, whether authoritarian or democratic, claim that they are best equipped to deal with the COVID-19 pandemic and are able to manage the social, economic and human-life cost of this disease. There is some concern that a lasting effect of the COVID-19 pandemic could be a resurgence of authoritarianism where we see what Shaun Walker, foreign correspondent for *The Guardian*, describes as a "…political age in which soft authoritarians have turned harder, and the surveillance state becomes a way of life even in some democracies". Indeed, as Jonathan Pearlman, editor of *Australian Foreign Affairs*, notes, this pandemic has geopolitical implications where we see a debate on the resilience of democracy in the time of COVID-19 or the rise of authoritarianism as "…COVID-19 is testing the resilience of the health, political and economic systems of different states".

Democracies are generally regarded as more transparent than authoritarian systems. This is because of democratic values associated with civil and political liberties, including the right to access information, freedom of expression and speech, and norms of accountability and the free flow of information, as well as freedom of assembly, to allow people to govern. Indeed, according to an analysis by *The Economist*, "for any given level of income, democracies appear to experience lower mortality rates for epidemic diseases than their non-democratic counterparts". Authoritarian regimes, however, "may be poorly suited to matters that require the free flow of information and open dialogue between citizens and rulers", the article said.

The initial response in China to COVID-19 seemed to support this notion. Information was suppressed and those involved in identifying a potential new respiratory illness were disciplined for spreading rumours, for

example, Dr Li Wenliang who later succumbed to COVID-19. Yet, looking at the global response, the performance of democratic vis-à-vis authoritarian regimes presents a mixed picture in successfully curbing the spread of the virus. France, the United Kingdom and the United States (the pinnacle of democratic norms) have registered far different responses than their Asian counterparts of Singapore, Taiwan, and Hong Kong. While some lauded this as different steps and capacity of governments to deal with a public health crisis, a key question remains: What lessons can we learn from the COVID-19 pandemic for democracy's future?

Democracy Digest highlighted four key areas that may undermine democratic functioning and open the space for more authoritarian measures to take hold in democratic states. These were centralising power, curtailing fundamental rights, expanded state surveillance of citizens, and banishing protests. In commentary published by Carnegie Endowment, Frances Z. Brown, Saskia Brechenmacher and Thomas Carothers highlighted that:

> *"There are already signs that some governments are using the crisis to grant themselves more expansive powers than warranted by the health crisis, with insufficient oversight mechanisms, and using their expanded authority to crack down on opposition and tighten their grip on power. Thus, the pandemic may end up hardening repression in already closed political systems, accelerating democratic backsliding in flawed democracies, and further bolstering executive power in democratic countries."*

A cursory glance at different responses from a variety of authoritarian, hybrid, and democratic states show that, indeed, the pandemic has opened up the space to test not only the resilience of democracy, but to what extent power will be abused and expanded in the name of protecting citizens. Hungary, a flawed democracy now classified as a non-democratic state by the Varieties of Democracy measure, has enacted measures to allow incumbent Prime Minister, Viktor Orbán, to rule by decree for an indefinite period of time and has criminalised the spreading of false information about COVID-19, Walker wrote. South Africa has also criminalised the spread of false information related to the coronavirus, as well as nationalised all water resources current national state of disaster. Freedom of movement has been curtailed and the South African Defence Force and Police Service now roam the streets to enforce the stay-at-home directive from the government. Military personnel monitoring and enforcing stay-at-home decrees are part of a "new normal" in a number of European and African countries, including Belgium, Spain, France, Italy, South Africa and Kenya, as countries are now *at war* with the virus. A number of states, including South Africa, Kenya, Nigeria and Zimbabwe, have flagged human rights abuses perpetuated by the military against the very citizens they are meant to protect in this war. Freedom of assembly has been curtailed in South Africa as well as a number of other states, including Hong Kong, a country rocked by mass pro-democracy protests in recent times.

A number of states have postponed elections, including France and some states in the United States of America, raising serious question around maintaining legitimacy of governments when elections cannot take place in an era of uncertainty.

Yet, despite some countries taking extraordinary measures to undermine democracy, others have taken softer measures, relying on state-civic relationships and voluntary compliance to enforce the required lockdown. South Korea had a strong focus on civil society while Taiwan advanced a political message of coordinated action by ordinary citizens and individual compliance to curb the pandemic. And, as Rachel Kleinfeld, senior fellow at the Carnegie Endowment for International Peace highlights, "the success of governmental social control depends more on voluntary compliance than on government enforcement". Ultimately, she argues, the successful enforcement of any measure to curb the spread of COVID-19 comes down to trust in governments and perceptions of legitimacy. If governments engender a strong perception of legitimacy in the political imaginary of people, and enjoy high levels of trust because people see the state as completely transparent and not politicising the pandemic, citizens are more willing to voluntarily cooperate with government decrees limiting freedoms. Concomitantly, while we may assume that political trust is generally lower in authoritarian regimes, Italy continued its *business as usual*, ignoring social distancing and a stay-at-home directive from government, wrote Rachel Donadio, a Paris-based writer, covering politics and culture across Europe in *The Atlantic*. A key reason could be because 93% of Italians did not trust their parliament. Many democracies across the globe, including South Africa and the United States, face increasingly low levels of political trust because of "…polarisation, inequality, and a sense of failed promise", according to Kleinfeld. This directly affects the ability of democracies across the globe and the African continent to effectively curtail the COVID-19 pandemic. Indeed, as she observes:

> *"Governments with high levels of trust can effectively maintain onerous lockdowns. Equally important, trust enabled some countries to convince their citizens to allow mass testing and quarantine before the virus's effects were widely seen, allowing them to stop the spread early."*

During the lockdown, a few worrying incidences have been reported, such as the attempt to force doctors into quarantine and alleged beatings and threats in Masiphumelele, as reported by photojournalist Jacques Marais. Political trust is essential in a time of crisis. It is the only way to ensure full cooperation from citizens in a time of war with a virus. Let us hope that the need to value political trust will not become another painful lesson from the COVID-19 pandemic for the South African state, and the globe as a whole.

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NOT A 'SKOP, SKIET EN DONNER' MOMENT:

Defence Force deployment in the time of COVID-19

With the deployment of the South African National Defence Force (SANDF) for three months to assist the police in containing COVID-19, it is important to reflect on the nature of civil-military relations in the country, and the influence that this mission may have on continued public support. Looking at national survey data on attitudes towards the SANDF, *Jarè Struwig, Dr Ben Roberts and Dr Steven Gordon* point out that the public's high level of trust in, and support of, the SANDF is likely to be critically tested by the conduct of soldiers during the national lockdown.

On 23 March, President Ramaphosa announced a 21-day national lockdown, and stated that the SANDF would be deployed countrywide to support government's efforts to reduce the spread of Covid-19. Three days later, on the eve of this operation, the Commander-in-Chief appeared in military uniform to address SANDF personnel. He referred to the mission as the most important in the country's history due to its focus on protecting and saving civilian lives in the face of a rapidly spreading global pandemic. In a directive to the soldiers, he stressed that the operation would be conducted in the most "understanding, respectful and supportive" way. "The people of our country will be looking upon you as their defenders ... the defenders of our nation, and you will need to restore trust and confidence".

In 2019, the South African National Defence Force was deployed to assist the police to quell gang violence on the Cape Flats in Cape Town. During the COVID-19 lockdown, they went back to support the government's efforts to reduce the spread of the disease.

Photo: *Ashraf Hendricks/GroundUp*

Deployment as part of a broader defence mandate

The decision to deploy the SANDF was to be expected, given that it has assisted the police regularly in recent years. Examples include army deployment to the Cape Flats in 2019 to assist the police to maintain law and order, and helping to curb xenophobic violence in Johannesburg and KwaZulu-Natal in 2015. This is in line with the idea of a broader defence mandate, as suggested in the 2014 South African Defence Review. Apart from defending and protecting the country, a strong developmental role is envisaged, such as applying military expertise to assist with projects like the rehabilitation of the Vaal River between 2018 and 2020.

Public opinion: A key weapon in the war against the COVID-19

Public attitudes towards the SANDF and the police will be key to the success of attempts to bring the COVID-19 pandemic under control through enforced lockdown procedures. Trust in an institution such as the SANDF is influenced by perceptions of fairness and effectiveness.

In turn, trust promotes legitimacy, by encouraging a sense of shared moral values, a perception that SANDF personnel comply with the law and a belief in the duty to obey them. Finally, trust and legitimacy encourage the willingness to cooperate with the SANDF, and, in the current context, adhere to the lockdown regulations to socially isolate.

The nature of public contact with deployed soldiers in their areas of residence during coming weeks has the ability to either enhance or erode trust, legitimacy and compliance. The media also has a role to play in providing the public with information about the conduct of army personnel during the COVID-19 operation. If the SANDF is not seen as a trusted, legitimate institution, communities might deliberately disregard national regulations and act out in ways that provoke the soldiers.

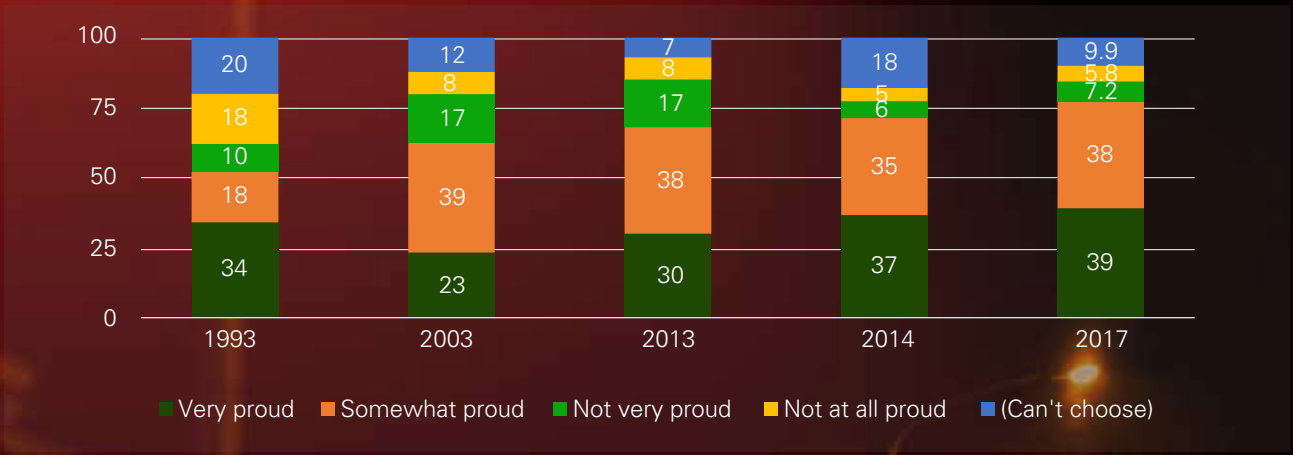
The good news: Robust public support for the SANDF

The HSRC Omnibus Survey of April 1993 and the South African Social Attitude Survey (SASAS) rounds of 2003, 2013, 2014 and 2017, include trends in the public's attitude towards the SANDF. These surveys represent the views of adult South Africans of 16 years and older, nationally.

Pride in the SANDF. To gain an overall view of how South Africans feel about the SANDF, a question was posed about pride in, and the legitimacy of, the SANDF over nearly

25 years. In 1993, as shown in Figure 1, 52% of South Africans were either very proud or somewhat proud, and by late 2017, this had increased to 77%. These results point to an improving public image of the SANDF over the last two decades.

Figure 1: Changing pride in the SANDF over two decades, 1993-2017 (percentage)



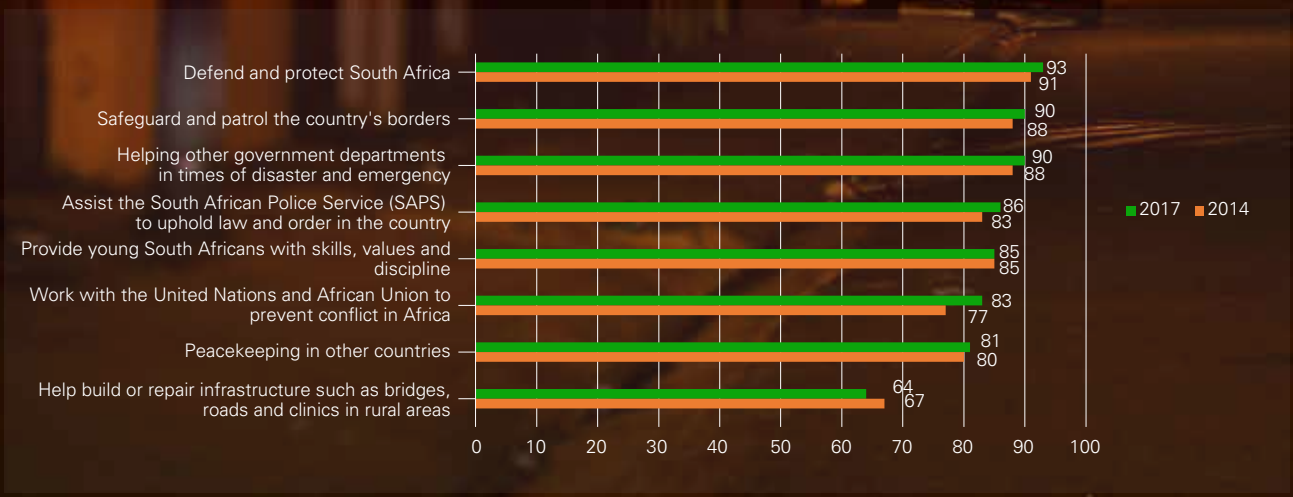
Note: The comparison with the 1993 data should be treated with some caution, given the different scaling.

Sources: HSRC Omnibus Survey April 1993; HSRC SASAS 2003, 2013, 2014, 2017.

Supported roles for the SANDF. In line with the strategic defence goals and tasks outlined in the 2014 Defence Review, respondents to the 2014 and 2017 SASAS surveys were asked their degree of support for a range of traditional and less conventional military roles. From the results (Figure 2), it would appear that South Africans generally deemed the conventional roles of the SANDF to be paramount, notably defending and protecting South Africa and safeguarding the borders (supported by 93% and 90% respectively). Furthermore, in 2017, 90% of South Africans indicated support for the expanded role of helping other government departments in times of disaster or emergency, and 86% were supportive of the SANDF assisting the SAPS to uphold law and order in the country.

These percentages clearly indicate that the public sees value in the SANDF in assisting to uphold law and order, and assisting in times of disaster or emergency. Interestingly, the defence roles that ranked lower than others but still received high support were helping to build or repair infrastructure such as bridges, roads and clinics in rural areas, and working with organisations such as the United Nations and African Union to resolve conflict in Africa.

Figure 2: Supported roles for the SANDF, 2014 and 2017 (% 'very' or 'somewhat' important)



Sources: HSRC SASAS 2014, 2017

The potential risk: Allegations of abuse

A source of concern, from a public opinion perspective, is the alleged cases of abuse of authority by deployed SANDF personnel. During the first week of the lockdown, video footage shows soldiers forcing people who were flouting lockdown restrictions to do squats, push-ups and roll on the floor. This resulted in calls for investigations by the Military Ombud and disciplinary action, and has led the defence minister Nosiviwe Mapisa-Nqakula to condemn such unlawful actions and appeal for deployed soldiers to play a positive role in their interactions with citizens. While these alleged abuses were probably isolated incidents, they received widespread coverage in the domestic and international media and on social media, and have the potential to negatively influence attitudes towards the SANDF.

South Africa is not alone in this challenge. Condemnation of alleged abuse of power and excessive force meted out by security personnel during COVID-19-related curfews and lockdowns have been reported in a growing range of countries. These have included reported incidents in India, Kenya, Rwanda, Mauritius, Paraguay, the Philippines, Hong Kong and France. In many cases, alleged abuse tended to disproportionately affect the poor and vulnerable. Poorer citizens often live in low-income neighbourhoods, settlements and villages where living spaces are cramped and poorly ventilated, with limited access to basic household services such as water and sanitation. Limited income means that stockpiling of basic food and other provisions is improbable, and COVID-19 restrictions on movement become highly challenging.

The infringement on human rights by excessive force and humiliating punishment will undermine trust in the SANDF, which could lead to a disobedience of regulations and contribute further to the spread of the virus.

The mission ahead

From the figures and data presented above, it is apparent that most South Africans support a more expansive defence mandate and have grown prouder and more trusting of the SANDF. But the COVID-19 crisis will be a litmus test for the defence force.

As President Ramaphosa remarked upon SANDF deployment, "this is not a moment for skop en donner. This is not a moment for skiet en donner. This is a moment to be supportive to our people. When they see you patrol with your guns, they will be fearful, but make sure that when they see you, they see the kindness of the state of South Africa". We can only hope that the security forces heed this message of compassion and that the battle is fought against the virus and not against our people.

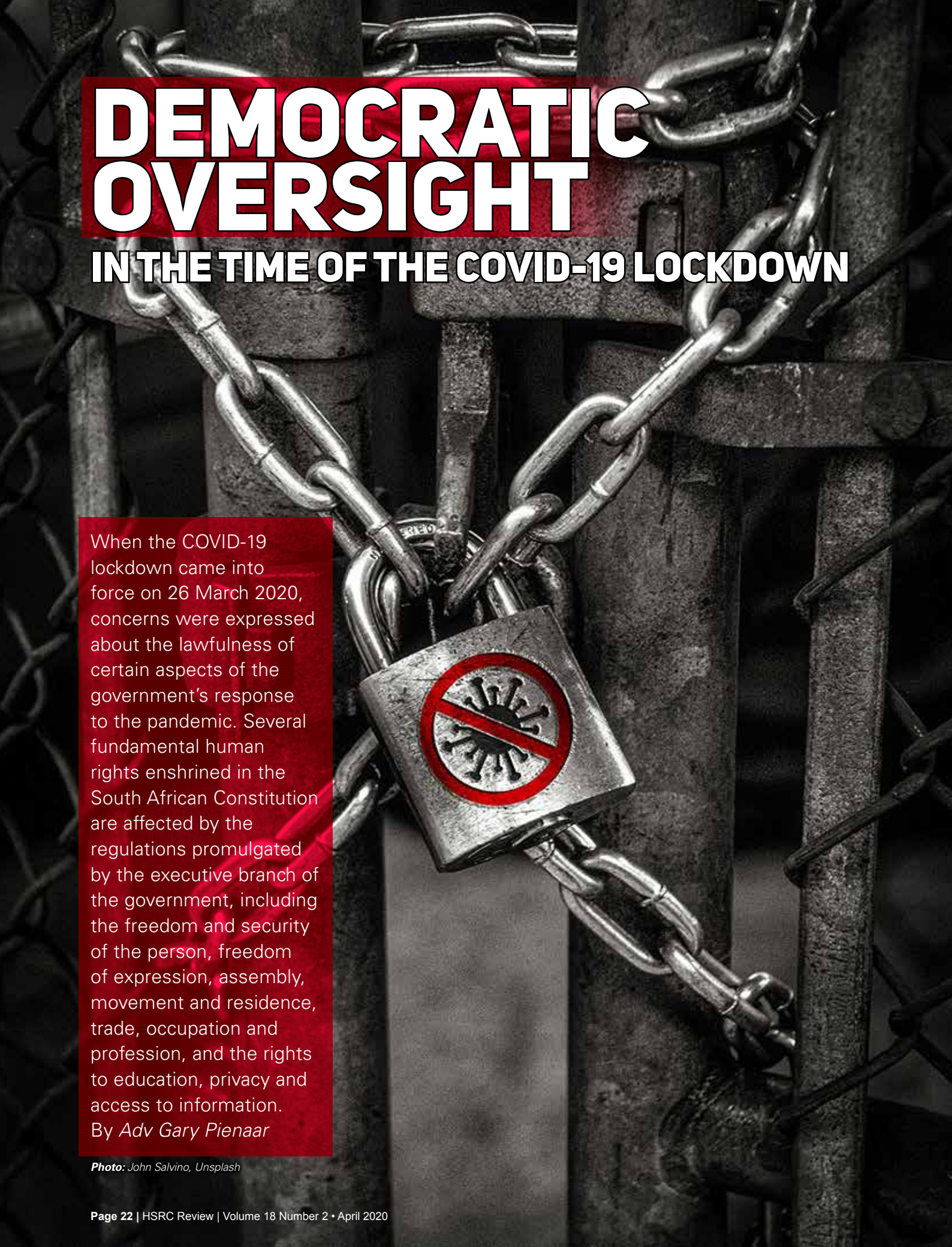
Authors: *Jarè Struwig and Dr Ben Roberts, chief research specialists and coordinators of the South African Social Attitudes Survey, Dr Steven Gordon, senior research specialist, in the HSRC's Democratic, Capable and Ethical State division.*

Note

'Skop, skiet en donner' translates literally from Afrikaans as 'kick, shoot and hit', and is a phrase generally associated with violent action and melodramatic adventure (often in the context of films). The 2014 and 2017 SASAS data on attitudes towards the SANDF is derived from work commissioned by the SANDF.

DEMOCRATIC OVERSIGHT

IN THE TIME OF THE COVID-19 LOCKDOWN



When the COVID-19 lockdown came into force on 26 March 2020, concerns were expressed about the lawfulness of certain aspects of the government's response to the pandemic. Several fundamental human rights enshrined in the South African Constitution are affected by the regulations promulgated by the executive branch of the government, including the freedom and security of the person, freedom of expression, assembly, movement and residence, trade, occupation and profession, and the rights to education, privacy and access to information.

By *Adv Gary Pienaar*

Photo: *John Salvino, Unsplash*

In the spirit of *'thuma mina'*, most South Africans responded positively to President Cyril Ramaphosa's call for a national COVID-19 lockdown. Many citizens and commentators indicated their preparedness to surrender aspects of their civil and socioeconomic rights in the interest of the common good and the compelling exigencies of the crisis, recognising the necessity of prioritising the right to life of the many who might succumb.

Judicial oversight

After some confusion involving the location of judicial authority between some divisions of the High Court and his office, Chief Justice Mogoeng Mogoeng and the heads of courts held a media conference on Tuesday 17 March 2020 during which Mogoeng announced directives stipulating that, as a designated essential service, the justice system would carry on, with a number of measures to ensure hygiene and physical distancing. Urgent matters would proceed and members of the public with a 'material interest', including litigants and those supporting them and the media, would be allowed in court.

Mogoeng instructed the courts to stay open during the lockdown, among other reasons so that citizens could challenge the lockdown rules if necessary. The Constitution makes provision for such challenges, even under a state of emergency, which gives the government extraordinary powers, beyond those it now has in terms of the declared national state of disaster.

Fake news and surveillance

Since the lockdown, a number of people have been arrested for flouting the lockdown regulations, amongst them a man who allegedly spread potentially dangerous false claims of contaminated tests. The Gauteng department of health reportedly encountered difficulties with its community-testing initiatives as a result of the false claims.

However, the fake news provisions are extremely vague, to the extent that they may be unenforceable. Intention, for example, is always difficult to prove.

On 26 March 2020, Stella Ndabeni-Abrahams, Minister of Communications and Digital Technologies, promulgated the 'Electronic Communications, Postal and Broadcasting Directions'. This included instructions to telecommunications companies to maintain the availability of their services during the lockdown, as part of a package of measures providing reassurance that the free flow of official, private and social news and information would continue.

At the same time, Direction 8 required that internet and digital telecommunications licencees had to provide location-based services in collaboration with the relevant authorities to combat the spread of COVID-19.

This provision caused consternation as it authorised the government to 'track and trace' people's location and movements using their private cellphones. This broadly-phrased power raised the spectre of state surveillance using digital location and interception of communications, which were reminiscent of apartheid-era spying and movement control, as well as of more recent political abuses of state security capacity. South Africa is not alone in introducing such measures, which are increasingly applied both here and elsewhere in the world, including newer democracies in Europe.

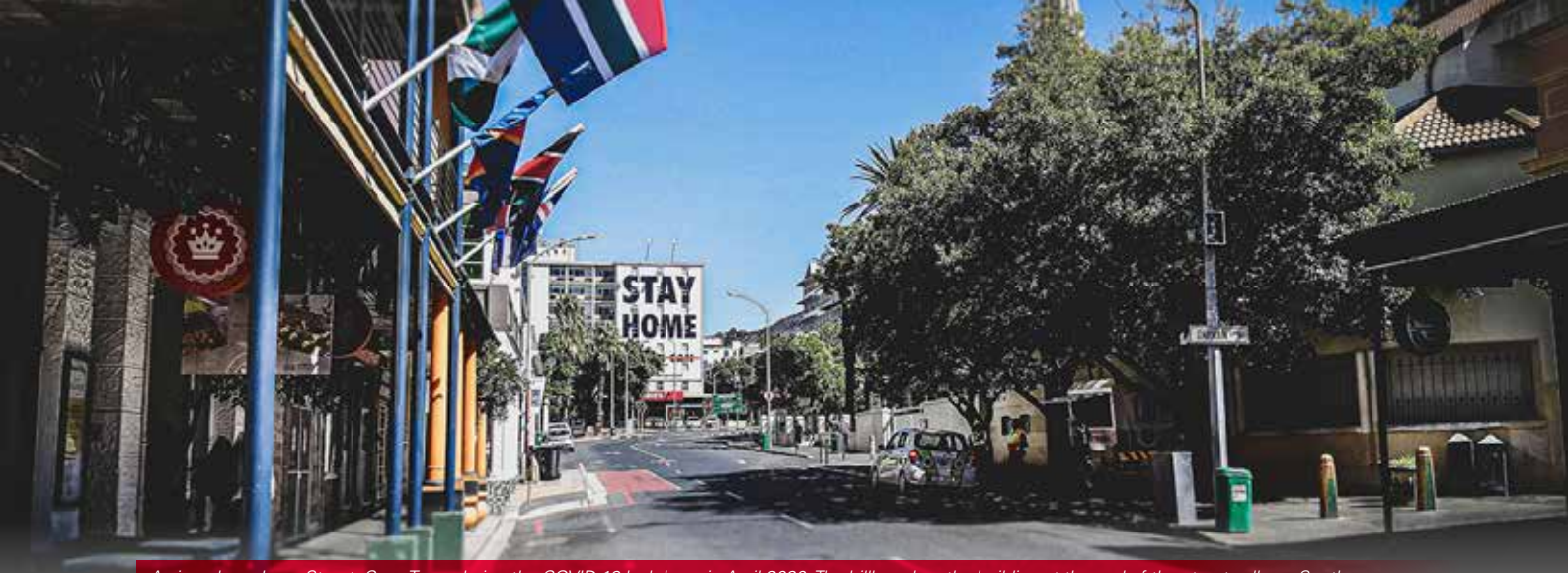
In many countries, the crisis has also been used to limit the right of access to information — an essential enabling right in any situation, and particularly when ordinary democratic checks and balances have been constrained in various ways.

Given the new offence of spreading fake news, many people feared that the content of their communications would also be accessible to state surveillance. These fears arose because Direction 8 of the regulations contained none of the democratic safeguards of a clearly and narrowly specified purpose for accessing clearly specified categories or types of information, how the information would be used, whether it would be anonymised, and the duration the information would be stored, as well as prior judicial authorisation.

The government's reassurance that it would not engage in 'intrusive' surveillance wasn't uniformly accepted at face value. Subsequently, amended regulations promulgated on 2 April 2020 provided much-needed detail and greater reassurance in this regard. For example, while a track and trace database with personal details would be created, it would be confidential, and disclosure of the information would be permitted only for purposes related to addressing, preventing or combatting the spread of the virus. This personal information could be retained only for a period of six weeks after being obtained and would thereafter be destroyed.

No person would be allowed to 'intercept the contents of any electronic communication' — Reg.11H (12). The amended regulations also required the appointment of a retired judge as the COVID-19 Designated Judge, to make recommendations and give directions regarding the enforcement or amendment of the regulations, to safeguard people's right to privacy. In a widely welcomed move, the minister of justice promptly appointed the highly respected retired Constitutional Court Justice Kate O'Regan to undertake these responsibilities.

In a further welcome move, the Information Regulator of South Africa, the guardian of access to information and privacy in terms of the Protection of Personal Information Act 4 of 2013, issued a detailed Guidance Note on 3 April. The Regulator recognised the need to effectively manage the spread of COVID-19, but outlined the conditions for the lawful gathering and processing of personal information with which public and private bodies needed to comply when entrusted with personal information.



A view down Long Street, Cape Town during the COVID-19 lockdown in April 2020. The billboard on the building at the end of the street calls on South Africans to "stay home" to help the government's efforts to contain the pandemic.

Photo: *Discott*

Lockdown enforcement

The lockdown is being enforced by the SA Police Service with support from metropolitan police services and the army. However, Regulation 11E states that "no person is entitled to compensation for any loss or damage arising out of any bona fide action or omission by an enforcement officer under these regulations". This regulation does not provide blanket immunity for misconduct by the security forces, but commentators have expressed concern that it gives them more cover than under normal conditions.

Relevant oversight bodies — the Independent Police Investigative Directorate (IPID) and the Military Ombudsman — are operating with reduced capacity or without urgency. An IPID media statement on 25 March indicated that its services remained available during the lockdown period. Although it had only a limited number of investigators on standby in each province, provincial management would ensure that its work would continue. Its website provides standby mobile numbers for each province. On 2 April, the military ombudsman publicly confirmed the availability of its services during the lockdown.

Parliament

Despite the unprecedented crisis facing the country, and the exceptional concentration of power assumed by the executive branch, Parliament commenced its scheduled recess and constituency period on 18 March, within three days of the disaster declaration, suspending all sittings until 13 April 2020.

On Friday 27 March, the Parliament's presiding officers issued a media statement saying that:

"Members of Parliament, who are classified under the lockdown regulations as amongst those performing essential services, will be fulfilling their constitutional responsibilities during this period, in their constituencies in support of efforts against COVID-19."

The statement provided no guidance or direction as to how the members of parliament are to fulfil these constitutional responsibilities, including the duty to scrutinise and oversee executive action, or the duties to facilitate public participation in oversight during a lockdown. Its duty to ensure transparency is vital when the DMA requires the Disaster Management Centre to file only an annual report with parliament.

Parliament initially issued a few media statements calling on the minister of health to investigate reported shortages of personal protective equipment at public health-care facilities, and calling on the heads of the police and army to investigate allegations of their members' abuse of authority. But it didn't respond to calls by civil society to all legislatures and rejected a request by the official opposition to the Speaker of Parliament to ensure at least some committee oversight. This led to a widespread view that they were abdicating their responsibilities.

There is an urgent need to ensure transparent and timely answers that provide the public with vital information about the implementation of government's undertakings. Key examples include: details of government's progress in providing vital personal protective equipment to health-care workers; the rollout of the COVID-19 testing programme; progress with emergency provision of water to unserved communities; the issuing of permits to informal traders; the provision of social relief for those in need of food and other essentials; and the provision of promised financial relief for individuals and small and medium companies.

On 15 April 2020, the Speaker issued rules for virtual meetings, which included public participation via livestreaming. The Parliament announced the resumption of oversight duties by means of virtual meetings and the cancellation of members' scheduled leave from 28 April to 4 May 2020. Work related to COVID-19 oversight would be prioritised. The chairperson of the Portfolio Committee on Police, Tina Joemat-Pettersson, announced plans for a committee meeting, but did not indicate a date. The Defence Committee has also been silent about scheduling a meeting to receive updates concerning investigations into allegations of SANDF members' alleged misconduct.

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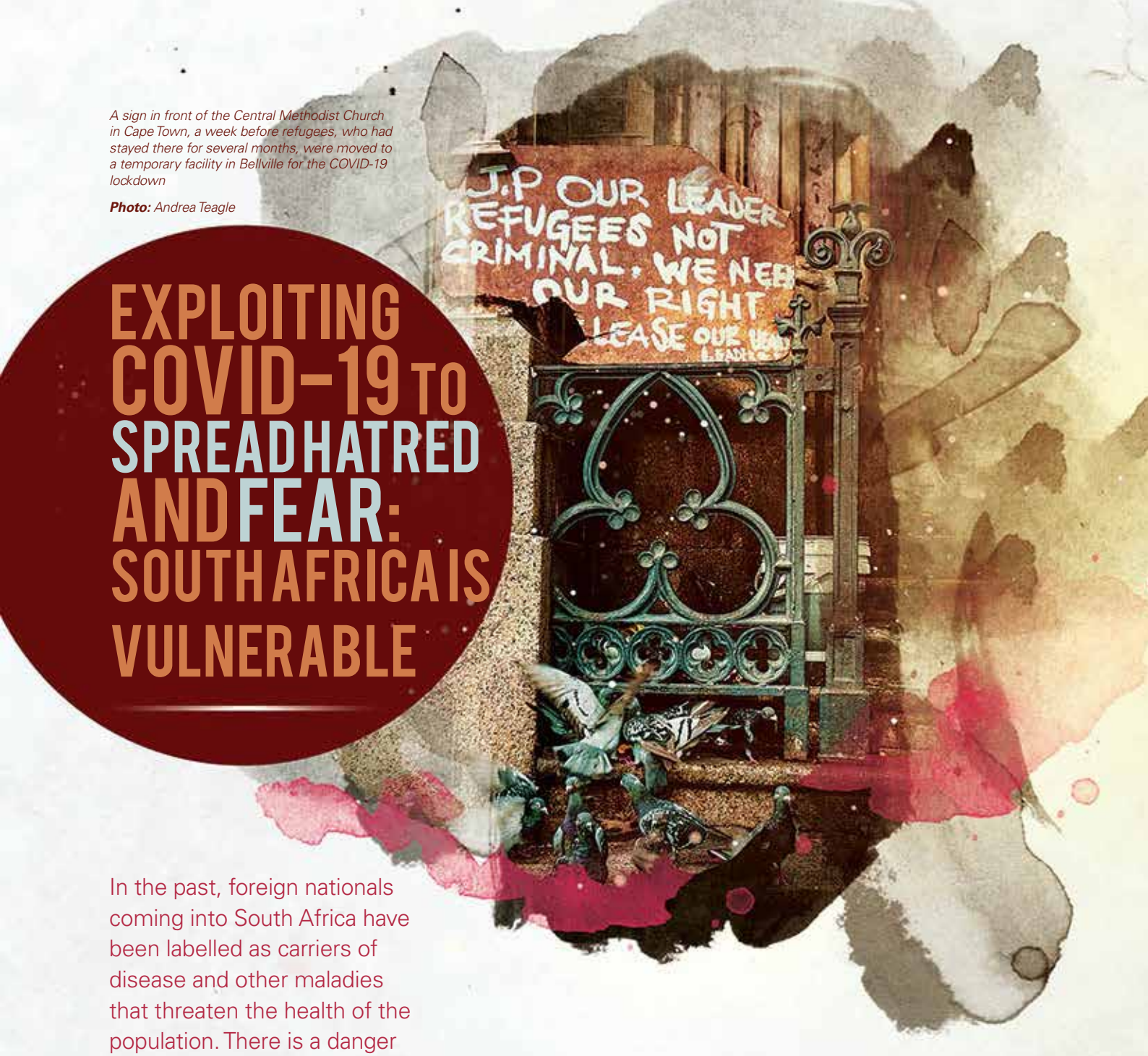


A sign in front of the Central Methodist Church in Cape Town, a week before refugees, who had stayed there for several months, were moved to a temporary facility in Bellville for the COVID-19 lockdown

***Photo:** Andrea Teagle*

EXPLOITING COVID-19 TO SPREAD HATRED AND FEAR: SOUTH AFRICA IS VULNERABLE

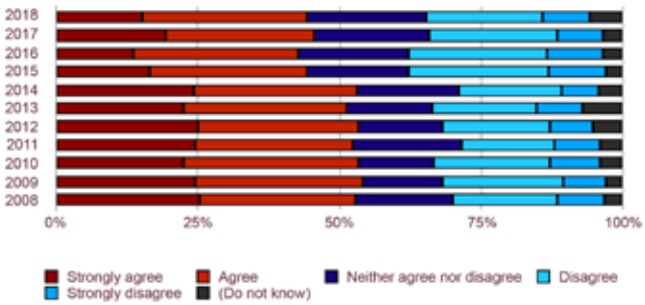
In the past, foreign nationals coming into South Africa have been labelled as carriers of disease and other maladies that threaten the health of the population. There is a danger that the COVID-19 pandemic could result in an upsurge in such aggressive anti-immigrant sentiments, as has been observed elsewhere in the world. The HSRC's *Dr Steven Gordon* explores this likelihood, using data about attitudes towards migrants from the South African Social Attitudes Survey (SASAS).

Ever since the start of the COVID-19 pandemic, politicians around the world have attempted to exploit the crisis for their own ends. In countries like Hungary and Poland, right-wingers have latched onto the crisis to push anti-immigrant agendas and seize more power. In one prominent example, populist Italian leader Matteo Salvini demonised African asylum seekers as carriers of the virus in February 2020. Such politicians have claimed that the outbreak gives credence to their past calls for aggressive immigration restrictions.

The COVID-19 crisis seems to be fuelling anti-immigrant animosity in places where foreigners are already scapegoated for other evils such as crime and unemployment. Given how immigrants are often similarly blamed in South Africa, there is a risk that the COVID-19 pandemic could fuel dangerous anti-immigrant aggression in the country.

But how widespread are beliefs that immigrants are harbingers of disease and contamination in South Africa? To answer this question, we can look at data from the South African Social Attitudes Survey (SASAS). The survey series is administered by the HSRC and first started looking at public views on the link between international migration and disease in 2008. To obtain a picture of the country's population, SASAS used a nationally representative probability sample of adults in the nation's nine provinces aged 16 years and older and living in private households. More than 3000 South Africans participated in interviews conducted between mid-November and mid-December.

Figure 1: Public attitudes about whether immigrants spread disease in South Africa, 2008-2018



Source: South African Social Survey (SASAS) series 2008-2018

In order to understand public attitudes towards foreigners and the spread of disease, SASAS respondents were asked if they agreed or disagreed that foreign nationals brought disease into the country. Responses for the period 2008-2018 are presented in Figure 1.

In 2008, approximately half (53%) of the respondents agreed that immigrants spread disease and only a minority (27%) disagreed with the statement. The popularity of this belief began to fall in 2015 and only 44% of the population held this opinion in 2018. These results show that beliefs about the health risk of foreign nationals are widespread but that civil society and government have had some success in reducing this anti-immigrant narrative.

As one might imagine, perceptions about the link between foreigners and disease have an impact on the general public's hostility towards the foreign-born. Let us consider welcoming predispositions in 2018. A quarter of the adult populace said that they would welcome all immigrants to South Africa. This can be compared with 47% who reported that they welcomed some and 26% who welcomed none. Almost two-thirds (64%) of the least welcoming thought that immigrants were a health risk.

When considering public attitudes towards foreign nationals, the issue of anti-immigrant violence cannot be ignored. Past research has highlighted this kind of violence as a problem in South Africa. Opinions about the connection between non-nationals and disease were also high amongst those who had recently engaged in violent action against immigrants. Of those who said in 2018 that they had taken part in this kind of violence in the previous five years, 65% believed that foreigners were a major driver of disease.

Some South African politicians have, in the past, sought to blame foreign nationals for a lack of health-care resources. Despite the absence of published evidence, former Johannesburg Mayor Herman Mashaba has been particularly active in promoting this narrative, which has found traction among many South Africans. In SASAS 2018, 61% of the general public agreed with the statement that immigrants deplete the country's resources. Such scapegoating tends to ignore the fact that immigrants and refugees face numerous obstacles navigating the health-care system. It is heartening to see that Dr Zweli Mkhize, the current minister of health, has not pursued similar populist fear mongering. During periods of pandemics, it is beneficial for the general public health that all have access to medical care regardless of nationality.

During periods of public health crisis, politicians may see anti-immigrant narratives as a way to distract voters from their own failures and to shore up electoral support. For months, US President Donald Trump had, for instance, been calling the new coronavirus that causes COVID-19 by its common name. But then on 16 March 2020, he switched to a new moniker, the "Chinese virus", in an apparent effort to deflect blame from his administration's slow response to the pandemic. It now appears that Trump will make this anti-China messaging a central part of his 2020 re-election campaign and his confrontation with the World Health Organization seems to be part of that strategy. Such racialisations have happened previously, when Trump sought to build support for immigration restrictions by referring to African countries as "shitholes".

In his handling of the COVID-19 crisis, President Cyril Ramaphosa has shown greater discretion, dignity and competence than politicians like Trump. He has not sought to fuel xenophobic passion in these times of uncertainty. Indeed, the South African government should be lauded for its swift and decisive actions in response to the crisis.

When the lockdown ends and South Africa starts to rebuild the economy, we will need foreigners to start businesses and help create jobs. Empirical evidence from a recent joint study by the Organisation for Economic Co-operation and Development and the International Labour Organization shows that foreign-owned businesses and workers contribute meaningfully to the national economy. Of course, resources are scarce during times of crisis and there is a natural fear that newcomers will take more than they give. But it is important not to let fear of outsiders lead us to retreat from the world and a return to economic growth.

Politicians and government officials must be careful not to play into explosive anti-immigrant narratives during these days of doubt and anxiety. As has been shown here, such narratives are a danger to social cohesion in the country. And, as citizens, we must be wary of those peddling distrust of foreigners for their own selfish ends.

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Living through global trauma:

WHY SOUTH AFRICA NEEDS A PUBLIC MENTAL-HEALTH RESPONSE TO COVID-19

Rasta Paul sits alone in Greenmarket Square a day before lockdown. Without means of making an income, Paul, who sells art and drums to passers-by, is one of many despairing of being able to pay rent.

***Photo:** Andrea Teagle*

The mental-health effects of the COVID-19 pandemic form a significant part of the overall health risk. Failure to put in place measures to mitigate the psychological impacts of quarantine is likely to undermine its effectiveness and slow economic recovery. In South Africa, the stage is already set for major mental-health implications. By *Andrea Teagle*

As countries travel further along the road of social distancing, the psychological toll of the global COVID-19 pandemic is becoming more apparent. Yet, in South Africa, the mental-health impact of the pandemic received inadequate attention in the first month of lockdown.

"It is a global trauma that everyone is going through," says Dr Charity Mkone, a clinical psychologist and associate lecturer at Wits University. She warns that while measures might successfully flatten the curve, a failure to consider the psychological toll of the pandemic and incorporate a mental-health response, will come with dire costs to wellbeing.

Like the physiological-health impact, the mental-health burden is likely to fall unevenly across socio-economic divides. While lockdown underscores the comparative isolation of those living in affluent areas, in low-income areas, the stressors that contribute to an already high risk for mental illness are highlighted and exacerbated. These include food insecurity, health worries, crowded living, a lack of access to basic services, financial stress, and the risk of violence.

"What the lockdown has been able to do is really shine the light quite brightly on the disparities in our country, and expose what has always been there...," Mkone says. "People [in higher income brackets] are realising for the first time just how difficult conditions in informal settlements must be."

The psychological toll of quarantine

A rapid review published in *The Lancet* in February 2020, including 27 studies of the psychological impact of quarantine in response to epidemics in different parts of the world, found significant and, in some cases, long-lasting negative effects. These included post-traumatic stress disorder (PTSD), low mood, irritability, insomnia, anxiety, anger, and depression.

"There's so much uncertainty lurking and certainty is the one thing that we as human beings thrive on: knowing what's going to happen in our day, knowing what the week ahead of us holds — and the sense of control it gives us… no matter how false that sense of control is," Mkone says.

According to the *Lancet* review, quarantine stressors included infection fears, frustration, inadequate supplies, inadequate information, financial loss, and stigma. Longer quarantine periods — greater than 10 days, in one study — were associated with worse mental-health outcomes, including a higher risk of PTSD.

In a 2015 study included in the review, respondents from Liberia placed under Ebola quarantine experienced serious socioeconomic distress.

Poverty and mental health

In low-income areas, which are likely to bear the brunt of the impact of the pandemic, people already face a high risk for mental illness. Poverty and mental illness are widely understood to work in a vicious cycle — with the stress associated with poverty predisposing individuals to mental illness, while mental illness in turn increases the risk of falling into, or remaining, in poverty.

In a 2010 systematic review, Professor Crick Lund and colleagues from the University of Cape Town found that education, food insecurity, housing, social class, socio-economic status and financial stresses have "a relatively consistent and strong association with common mental disorders".

In South Africa, which is already experiencing exceptionally high levels of gender-based violence, domestic violence support centres have recorded a spike in calls since lockdown began. Researchers have also warned of the possibility of xenophobia in the coming weeks and months.

In a public lecture last year, HSRC CEO Crain Soudien pointed to the psychosocial aspects of inequality as little recognised factors behind the persistence of poverty in South Africa. Yet, mental health in South Africa receives a fraction of total health expenditure: according to a 2019 analysis of the 2016/2017 financial year, 5% of the total health budget. Fewer than one in ten South Africans receive the treatment they need.

To date, despite swift and commendable leadership from South African President Cyril Ramaphosa, there has been little mention of a public-health response that incorporates a mental-health component, despite the interplay between psychological and physiological health. Lund, who is also the director of the Alan J Flisher Centre for Public Mental Health, says that there is a need for a public mental-health response that targets vulnerable populations.

A 2004 study included in the *Lancet* review found that, among health-care workers in Taiwan who might have come into contact with severe acute respiratory syndrome (SARS), those who had been quarantined were more likely to experience acute stress disorder. Another study found that having been quarantined increased hospital employees' risk for PTSD symptoms three years later. This suggests that adequate psychological support of health-care workers will be critical to the continued functioning of South Africa's health-care system during and after the COVID-19 pandemic.

A comprehensive public mental-health response to the pandemic must address risk factors such as food insecurity, Lund says. President Ramaphosa's announcement of a R500 billion social and economic relief package on 21 April — that includes the called-for increase in the child-support grant — was widely welcomed in the face of the country's fifth week of lockdown and a looming humanitarian crisis.

Evictions, trust and mental health

During the lockdown, authorities have evicted hundreds of households from settlements in eThekwini, Cape Town and Johannesburg. At least 1000 people have been left homeless after the Red Ants demolished shacks in Lakeview, south of Johannesburg in mid-April, claiming that the structures were uninhabited.

The shack dwellers' movement Abahlali baseMjondolo has issued warnings that ongoing evictions fly in the face of efforts to curb the pandemic and contravene a moratorium on all evictions during the lockdown.

These instances, together with instances of police brutality in informal settlements, place additional stress on already vulnerable populations. They also serve to undermine trust in public institutions, which is critical to efforts to slow the spread of COVID-19.

Based on the trajectories of past epidemics, the *Lancet* rapid review found that community involvement, clear communication and voluntary quarantine protect against the worst psychological impacts and would be more likely to be successful in reducing transmission.

Where relations between informal settlements and municipal wards are already fraught, careful community engagement is even more critical.

Meanwhile, according to water and sanitation minister Lindiwe Sisulu, plans are underway to relocate thousands of people from densely populated townships. While Sisulu has stated that this would be undertaken sensitively, Lund warns that forced removal at a time of high anxiety and uncertainty is likely to have a major mental-health impact, and risks community backlash.

Where there is resistance, Mkone says, it does not mean that people don't care about their health. Rather, "it is because people are feeling very triggered. If you take note of the people who live in townships currently, it's either people who have themselves lived under the heavy-handed apartheid regime or their descendants… who have transmission of trauma from their parents and grandparents".

"The best thing you can do is to protect people, provide… security, food security, income security, and try and maximise ways of people getting social support from each other while minimising physical contact," Lund said. "If you start to, in that phrase 'decant people', forcibly remove them, you really are setting yourself up for an absolute social disaster."

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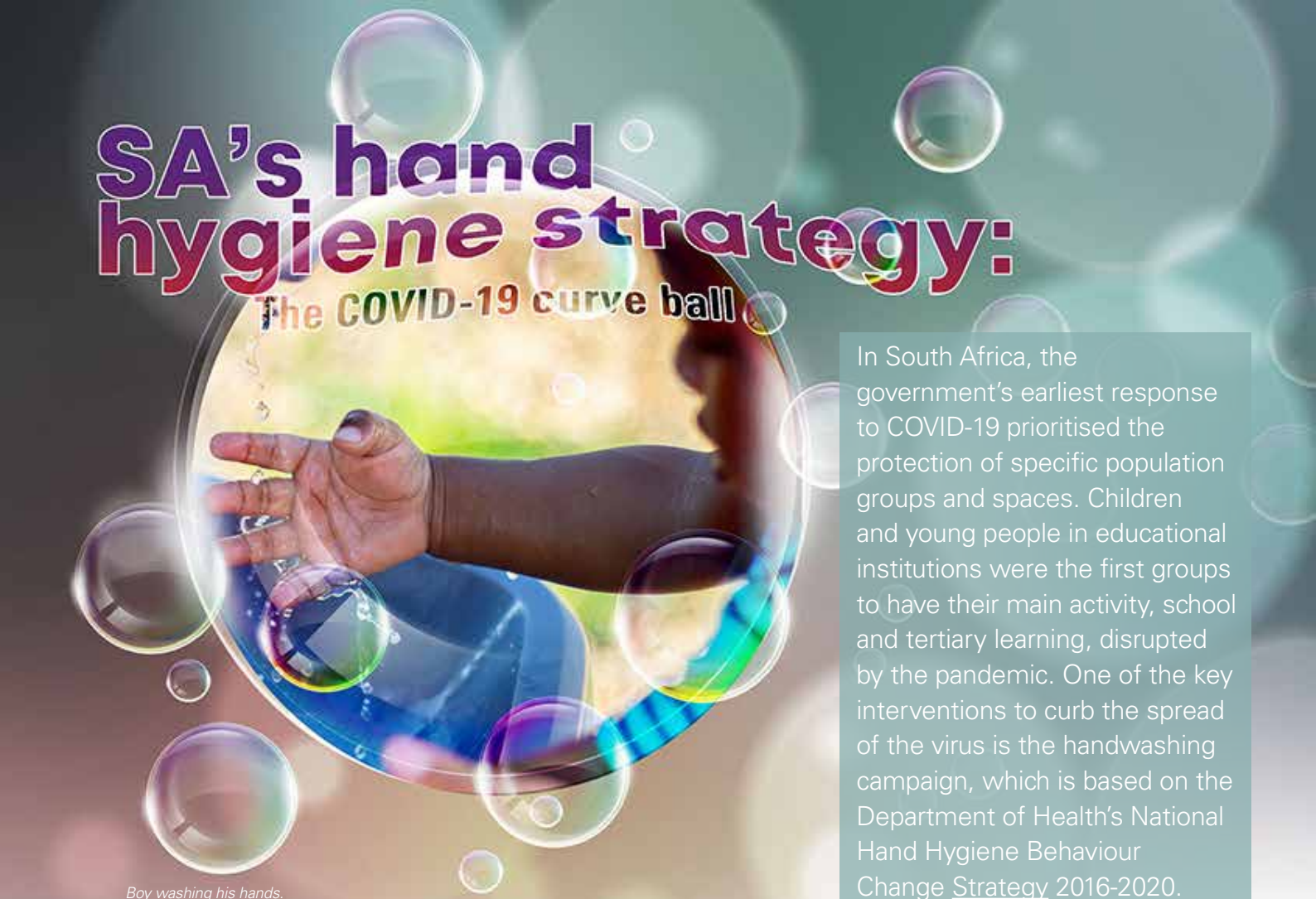
SA's hand hygiene strategy:

The COVID-19 curve ball



Boy washing his hands.

Photo: *Gelani Banks/Unsplash*

In South Africa, the government's earliest response to COVID-19 prioritised the protection of specific population groups and spaces. Children and young people in educational institutions were the first groups to have their main activity, school and tertiary learning, disrupted by the pandemic. One of the key interventions to curb the spread of the virus is the handwashing campaign, which is based on the Department of Health's National Hand Hygiene Behaviour Change Strategy 2016-2020. *Dr Mokhantšo Makoae, Tsidiso Tolla, Prof Charles Hongoro and Dr Emmanuel O. Sekyere* analyse the strategy and argue that it may have some challenges.

The South African government's national COVID-19 response is guided by the Constitution, which describes certain groups as vulnerable, including children. This is despite some emerging evidence that children may not be particularly susceptible to the coronavirus infection, related morbidity and mortality. Additionally, the government relied on international and national policy frameworks, which require collaboration across the health, human settlements, education, sanitation, water and hygiene sectors, as well as collaboration from business and families.

The World Health Organization (WHO), as provided for by the 2005 International Health Regulations, has the responsibility "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks". Drastic steps by the South African government have, accordingly, involved promulgating population-wide and inter-state legal instruments that target large-scale individual behavioural changes, including restriction of economic activities and mobility across spaces, maintaining social distancing, self-isolation at home; and trans-border inbound travel. To date, the decisive government response was an initial 21-day national lockdown from 27 March, later extended, which has been complemented by information-education-communication and campaigns for infection prevention, including handwashing.

The SA hand hygiene strategy

The Department of Health's National Hand Hygiene Behaviour Change Strategy 2016-2020 was developed within the UNICEF WASH framework and supports the hand hygiene campaign as core to the COVID-19 response. Of the key actions included in the COVID-19 health-education messages, frequent handwashing with soap and avoiding touching one's face are relevant to children. The majority of children are at home during the lockdown, some without parental supervision. Successful implementation of the 2016-2020 hand hygiene strategy is based on specific assumptions that may not be consistent with what is required from children to contain COVID-19.

The COVID-19 crisis and the emphasis on handwashing to prevent

the spread of the virus could be an opportunity for society to effect immediate and sustainable behavioural changes in children. It supports Sustainable Development Goals (SDG 3) to "Ensure healthy lives and promote wellbeing for all at all ages", which includes the target to end communicable diseases by 2030. However, as part of the national policy framework for the COVID-19 response, the hand hygiene strategy has glaring challenges that require an institutional rethink.

Touching faces

Firstly, in terms of public-health problems, the strategy seems to principally frame hand hygiene as an intervention to prevent childhood diarrhoeal diseases, which are rated the third largest cause of under-five mortality in South Africa. Although it recognises evidence that supports the effectiveness of handwashing with soap in the prevention of respiratory infections among children, its goal explicitly states: "To prevent and reduce the prevalence of diarrhoea and other diseases related to poor water, sanitation and hygiene, particularly in children under-5 years". The strategy relies on "critical moments" that should induce handwashing with soap, namely, before handling food or eating and after using a toilet (including after changing babies' nappies and before feeding a child or others). Overall, it does not anticipate mechanisms of infection transmission in the case of respiratory diseases, including the risk of exposing the mucous membrane in their eyes, nostrils and mouth by children touching their own faces. The notion that people should avoid touching their faces to prevent the spread of COVID-19 is new to the public's repertoire of maintaining health, even though it is well-documented in respiratory disease prevention literature.

Schools and mothers

Secondly, as most children of school-going age are at home during the lockdown, it is important to analyse the implementation framework of the 2016–2020 hand hygiene strategy, which identifies children and primary caregivers as the target population to develop the habit of handwashing with soap. At the household level, it emphasises mothers' and fathers' traditional gender roles as carers and providers, respectively. They are expected to be the change agents who introduce and support hand hygiene. Schools and early-childhood-development centres are also key in the implementation framework. In practice, the locus of implementation is educational institutions and evidence of community-level implementation is lacking. Mothers are explicitly targeted for preventing diarrhoeal infection among children under five, while schools and the health-care system are identified as settings for implementing behaviour change for older children.

Water

South Africa is a water-scarce country and access to water and related services is uneven, despite government prioritising service delivery. However, the national response to COVID-19 suggests possibilities. The structural constraints to the implementation of the hand hygiene strategy such as poor access to water and inadequate sanitation in some educational institutions and households mean that many impoverished communities continue to grapple with the contradictions relating to their quest to save and preserve water, and the expectation to practise frequent handwashing. The implementation of the 2016-2020 hand hygiene strategy should consider that, while most households have water and soap, its priority uses may be washing dishes, bathing and laundry. The predisposition not to wash hands with soap at critical moments suggests an internalised ranking of the uses of soap and water. Frequent handwashing with soap might be incongruent with socioeconomic realities of poor households and it may be considered a wasteful practice in resource-scarce households. Because of their developmental stage, children are closely monitored during periods of scarcity to ensure they do not waste resources, and parental vigilance is likely to intensify due to the lockdown and prevailing uncertainties. It can be difficult for communities to redefine their relationship with water during the pandemic, and effective motivation is required to increase children's participation in reducing the spread of COVID-19. The interventions by the Department of Human Settlements, Water and Sanitation, and distribution of bars of soap in Gauteng province demonstrate the government's appreciation of the challenges that are faced with the implementation of the strategy and should not be withdrawn after the COVID-19 crisis has ended.

COVID-19 as catalyst

COVID-19 is catalysing institutionalisation of the UNICEF WASH programme and providing a key moment for leveraging the hand hygiene strategy. It is the final year of this strategy's implementation in South Africa and some of the limitations and potential issues are being exposed by the COVID-19 pandemic. The temporary exodus of children from schools means that teachers cannot reach millions of children with nuanced hand hygiene education. Many children and their caregivers will learn that touching one's face is a possible factor in spreading respiratory infections and other nuances in the hand hygiene campaign through mass media. Longitudinal research is needed to assess the adoption of hand hygiene and its sustainability as a health-protecting habit among parents and children. COVID-19 could entrench individual and household hygiene habits, thus complementing the role of schools in this regard.

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COVID-19: LESSONS IN REMOTE LEARNING FROM CHINA AND EUROPE

The COVID-19 crisis is forcing the education sector, globally, to adopt innovations and technologies to continue delivering the curriculum. Pervasive inequalities in the education system before the pandemic are now exaggerated, with marginalised learners excluded from learning due to disparities in access to remote learning infrastructure, digital content and basic learning material. The challenges of inequality have already surfaced in Europe. The HSRC hosted a webinar in which panellists from China and Europe shared 'lessons from the future' with South African educators. Five important takeaways about remote learning emerged from the webinar. By *Prof Sharlene Swartz* and *Krish Chetty*.

Photo: *Sharon McCutcheon/Unsplash*

Photo: *Queven /Pixabay*

Video conferencing technology has given people across the globe the opportunity to get to grips with remote learning. While e-learning, massive open online courses (MOOCs) and virtual learning have had varied uptake throughout the world, the COVID-19 crisis has prompted an enormous leap forward in appreciating future possibilities.

However, we need to distinguish between remote learning in a crisis and various online modalities of learning. Once the pandemic has passed, we need to think carefully about how our practice should change into a new blended mode of teaching and learning. We need to do much more work on questions surrounding young people's ability to learn remotely, their engagement, the anxiety levels and levels of online expertise of educators, and the best combination of online and real-life learning and teaching.

Remote learning as a potential equaliser

The key questions participants asked before and during the webinar concerned the issue of inequality: How does a country such as South Africa even begin to compete with countries such as Italy and China in terms of students' access to technology, the price of data and the resources of the institutions themselves? How do we address the huge divide within South Africa regarding access to internet connectivity, devices and online resources?

While remote learning has the potential to become an equaliser by ensuring the same quality of education for all, access to the tools to make it possible is a matter that needs urgent policy attention.

While online access in China and Italy is more widespread and cheaper than in South Africa, an urban-rural divide still exists in China and a North-South divide in Italy. In China, cheap data and device costs enabled a rapid transition to online learning during the height of the COVID-19 crisis. In some European countries, governments provided physical devices to ensure learning occurred. In South Africa, where many students have to travel and be accommodated at high costs, remote learning offers potential if issues of access to data and devices can be overcome.

In other African counties such as Kenya, remote learning was supplemented by radio and television access, while in Egypt a centralised platform was created for students and teachers to interact, free from data charges. Ubiquitous internet connectivity at low or no cost seems to be the key to equality in accessing e-learning globally.

E-learning may be the first step to changing society

The COVID-19 crisis is possibly a catalyst to critical thinking in a long overdue focus on content in education. In addition, new learning skills need to be taught in a world where information is in huge supply, but critical thinking is not. When comparing online learning with classroom learning, one may find better exchanges and interaction online. But these possibilities have only just begun to be explored. There is much more work to be done including incorporating artificial intelligence (AI) and virtual reality into the learning experience and devising intentional online pedagogies that depart from passive learning methods and promote active learner engagement.

Furthermore, the COVID-19 crisis gives us an opportunity to leapfrog outdated technologies. The traditional routes to advanced technology applications need not be followed. Thus, 5G mediums or AI applications in online practicals could be made available to South Africa's poor, if suitable policy choices are made. Anxiety about these changes are natural, but as experienced in China, can be quickly overcome as people become familiar with the technology and appreciate the advantages it offers. China's preparation in terms of available infrastructure, devices and educators with the necessary skills supported their almost seamless transition. There were benefits experienced with remote learning, over real-life

experience: one could, for example, watch a missed lecture although without the benefit of real-life interaction.

Beyond access to support and quality

Teachers carry the burden of successfully navigating current infrastructure limitations. To better prepare for this challenge, they need access to free data and free resources just as much as the learners. However, it is important to support educators, beyond access challenges for themselves and their students. In Italy, for example, teachers required rapid, intentional training to adequately use the appropriate tools to successfully manage online learning. This steep learning curve is frequently one that learners are better equipped to manage than teachers, a phenomenon that requires reflection. The role of power in education has frequently been a topic of discussion, and now more than ever it is in play, but with the imbalance reversed.

We are only beginning to support teachers in delivering quality online education, as well as learning what requires a physical experience. The quality of online platforms varies greatly and is in danger of perpetuating the inequalities of real-life institutions. So, for example, in South Africa, while Technical and Vocational Education and Training (TVET) college websites are 0-rated by Telkom, thus allowing free access to resources, many online platforms of TVET colleges and historically black institutions are of poor quality.

Beyond teaching to creating learning communities

At the University of Bologna, in Italy, while the transition from real-life teaching to remote teaching was relatively easy, and facilitated well using Microsoft Teams software, it soon became apparent that formal teaching content was only one part of the educational enterprise. Shortly after online teaching began, the university set up a holistic programme to support learners, not only focusing on delivery through technology but on building and maintaining a community through remote learning. To this end, it provides social spaces for students to meet online, offers exercise videos produced by the real-life gym staff, and has curated a cultural programme offered by staff and students in music and drama departments.

Another key learning from the University of Bologna's experience is that, as weeks went by, the teaching staff began to share experiences and expectations. This mutual support ensured the mental health of lecturers as they struggled to maintain the same online pace as they could do in real life. Expectations of managers had to be redrawn, so that educators did not burn out from an "always on" and "everything new" mode. Unique to the COVID-19 crisis, was the expectation that we would "soon go back to normal", which will clearly not be the case. Helping each other to settle in for the long haul and an uncertain future has all become part of the remote-learning experience.

After the COVID-19 crisis, South Africa, as with the rest of the word, is likely to experience increased economic inequalities as jobs are lost and economies slow down. The time to innovate with regards to accessible and quality mass education is now, in the midst of the pandemic, so that once the crisis has passed there can be no going back to how things were, pedagogically and economically.

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Panellists: *Joshua Kobb, the vice-dean of Zhejiang University's International Business School in China; Paolo Motta from the European Institute for Political, Social and Economic studies, an Italian think tank with a focus on BRICS development programmes; Prof Peter Herrmann, a research fellow at the Human Rights Center in the Law School of Central South University in Changsha, China; and Dr Ilaria Pitti, a senior assistant professor in the Sociology and Politics Department at the University of Bologna in Italy.*

RUNNING REMOTE SEMINARS in a time of COVID-19

On 7 April 2020 the HSRC convened a webinar around remote learning in the time of COVID-19. The event attracted a large and diverse participant-base, with educators and researchers from six countries and a panel of four academics sharing lessons from remote-learning experiences in the education systems of China and Italy. Conveners *Prof Sharlene Swartz* and *Krish Chetty* detail how the webinar demonstrated the ways in which virtual learning represents a fundamental shift from the traditional educational model, and offered insights into how to convene a webinar.

Two weeks prior to its webinar entitled "Coronavirus - Lessons in remote learning from China and Europe", the HSRC invited collaborators from Italy and China to describe their experiences of e-learning as their countries went into lockdown and universities and schools were shut down. The intention was to learn together across global boundaries and to offer South African academics and educators "lessons from the future" (see article on page 31), since Italy and China, in particular, were a few months ahead of us in terms of their response to the crisis.

The online location allowed for global participation that far exceeded what seminars are typically able to accommodate: we received 171 responses and 143 people attended. Participants joined the webinar from Germany, Nigeria, Namibia, Singapore, the United Kingdom and South Africa. South African participants were from universities (just over half), technical colleges, schools, NGOs and government departments. This is a large audience for an academic seminar, notwithstanding its topicality. In order to accommodate such a large audience using video conferencing technology that participants were all accessing on their personal devices without technical support, we had to have a clear plan to ensure it proceeded smoothly and that it was as interactive and as contextual as possible. In the side bar on page 35, we summarise the steps we took before, during and after the webinar to achieve these aims.

We invited participants to submit questions to help guide the conversation. Fifteen of them did so, and asked about the 'digital divide' and access to learning materials as well as practical questions regarding assessments and how to cater for vocational education that required practical demonstrations. More philosophically, participants were concerned with how remote learning changes the fundamental nature of education: its pedagogy, principles of learning, and the relationship between teacher and learner. Others raised questions about dealing with anxieties amongst older educators, and were interested to hear about student responses to online learning.

We resolved frequently encountered problems of remote communication such as noise, connection problems, and orderly participation by beginning the webinar with a 60 second tutorial on etiquette and how the platform worked. Participants were quick learners, energy was high and the webinar proceeded smoothly. In addition, as we gained confidence in the technology, it became effortless to switch things up: for example, bringing in comments from the chat

room, asking organisers offline questions, and steering panellists (through the chatroom) to delve deeper into issues that participants were flagging as important.

WEBINAR TIPS

Before

1. Find a stable platform – Zoom worked superbly;
2. Send out invites, asking for RSVPs and inviting participants to submit questions for panellists to engage them and ensure a contextual seminar;
3. Use these questions to frame the input and thoroughly brief panellists beforehand (and include a test of the platform);
4. Ensure that speakers are prepared to use Zoom, are familiar with the webinar format and are briefed about the local context;
5. Invite participants to test their Zoom connections prior to joining the live event;
6. Manage numbers carefully, and ensure you don't exceed the Zoom limits - time or number of participants (our licence allowed 300 participants for unlimited time);
7. Allow 15 minutes beforehand to allow participants to greet each other and settle in;

During

1. Offer a brief etiquette briefing at the outset – with visuals to show how the platform works and to point out controls, e.g. how to put up your hand using the button provided, how to use the chat room, operate your microphone and camera;
2. Ensure a conducive environment for speakers by muting microphones and switching off cameras to save bandwidth while panellists are speaking;
3. Use a panel format so there are no attention sapping extended talks but rather a few rounds of input from panellists;
4. Enable and encourage the chat room and refer to these inputs in-between questions to panellists to keep the webinar "live";
5. Ask speakers to respond to comments and questions as they come up in the chat room;
6. Take a few rounds of questions from participants (using the virtual "putting up your hand" icon) or by verbally or visually jumping in;
7. Towards the end, allow for a two-minute reflection pause, and invite participants to offer key learnings or takeaways by writing them up in the chat room;
8. End with all microphones and cameras on for applause and vocal responses to build community and share energy;

After

1. Hang around afterwards online for further conversation;
2. Analyse chat room comments to set future direction of conversations; and
3. Put an edited version of the webinar on YouTube.

Ensuring participation and contextual knowledge

We used a panel format and asked each of our presenters to answer questions. It was easier than in real life to keep them to time because it felt less obtrusive to interrupt, nod, agree and move them on. This made the conversation feel agile, responsive and interactive.

A key facilitator to ensuring the webinar was interactive was the use of the chat function. People made comments during the presentations: agreeing, disagreeing, asking questions to clarify, and asking for more information. Speakers responded almost immediately, for example, offering examples of the apps used in China (TenCent's WeChat and Alibaba's DingTalk) and offering the name of the software used at the University of Bologna (Microsoft Teams). There was even a side conversation about whether 5G technology was harmful, which was repudiated by a flurry of discussion replete with reference to evidence and resources. Such a red herring question has frequently derailed seminars in real time, but here the chat function sorted it out without a blip in the progression of the webinar, with all participants able to multitask and see the argument in a side bar. Other special-interest groups also found each other in the chat room and people offered encouragement, reference articles, and after a request to do so near the end, a critical reflection or takeaway. The two-minute reflection pause allowed participants to share their energies and deep insights gained during the course of the webinar.

Overall we had 191 chat comments during the webinar (excluding private chats between people – which is also a feature of the Zoom platform), roughly divided into greetings and thank yous (35), questions asking for more information from a speaker (13), speakers responding to questions (15), side-bar discussions (23), general questions (25), general comments (29), technical issues (7) and final reflections (44).

We concluded the webinar formally after 1 hour and 45 minutes by asking everyone to turn on their microphones and cameras and applaud the speakers. This was accompanied by whoops and cheers and comments around how well the interaction had worked, some surprise at the stability of the platform, the large number of participants, the feeling of community despite the physical distance, and the robustness of the discussion. Also notable was that after we had formally ended, a number of people hung around "chatting" to each other and to presenters, just as they might have done in real life.

The webinar recording is now available on the HSRC YouTube page, and can be accessed here: https://www.youtube.com/watch?v=pUer5RTCoFY

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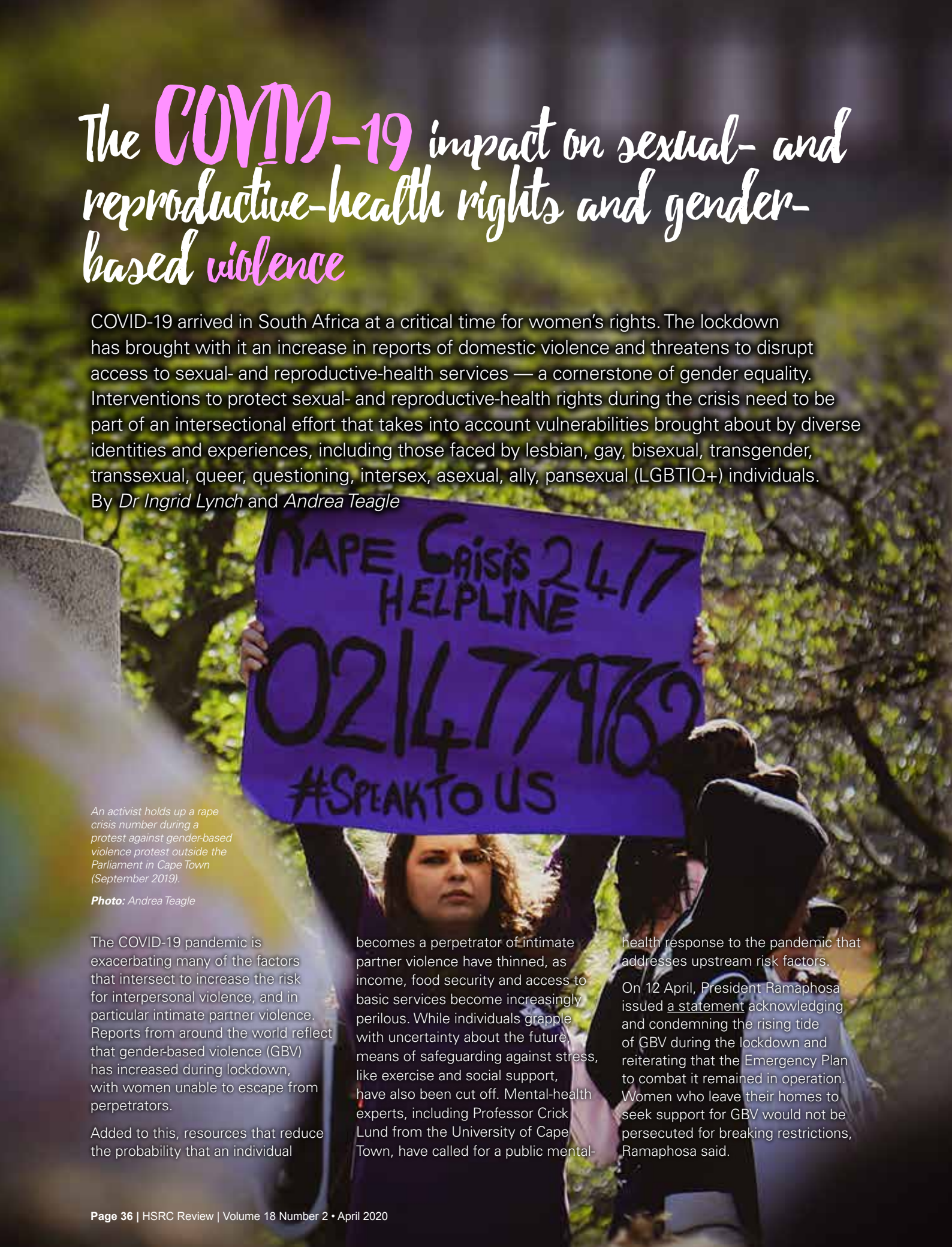
The COVID-19 impact on sexual- and reproductive-health rights and gender-based violence

COVID-19 arrived in South Africa at a critical time for women's rights. The lockdown has brought with it an increase in reports of domestic violence and threatens to disrupt access to sexual- and reproductive-health services — a cornerstone of gender equality. Interventions to protect sexual- and reproductive-health rights during the crisis need to be part of an intersectional effort that takes into account vulnerabilities brought about by diverse identities and experiences, including those faced by lesbian, gay, bisexual, transgender, transsexual, queer, questioning, intersex, asexual, ally, pansexual (LGBTIQ+) individuals.

By *Dr Ingrid Lynch* and *Andrea Teagle*



An activist holds up a rape crisis number during a protest against gender-based violence protest outside the Parliament in Cape Town (September 2019).

Photo: *Andrea Teagle*

The COVID-19 pandemic is exacerbating many of the factors that intersect to increase the risk for interpersonal violence, and in particular intimate partner violence. Reports from around the world reflect that gender-based violence (GBV) has increased during lockdown, with women unable to escape from perpetrators.

Added to this, resources that reduce the probability that an individual becomes a perpetrator of intimate partner violence have thinned, as income, food security and access to basic services become increasingly perilous. While individuals grapple with uncertainty about the future, means of safeguarding against stress, like exercise and social support, have also been cut off. Mental-health experts, including Professor Crick Lund from the University of Cape Town, have called for a public mental-health response to the pandemic that addresses upstream risk factors.

On 12 April, President Ramaphosa issued a statement acknowledging and condemning the rising tide of GBV during the lockdown and reiterating that the Emergency Plan to combat it remained in operation. Women who leave their homes to seek support for GBV would not be persecuted for breaking restrictions, Ramaphosa said.

Access to health care

Another concern is access to sexual- and reproductive-health (SRH) services for women and sexual and gender minorities, as human resources are diverted to the COVID-19 response. The impact of the pandemic means that, globally, such services and support — ranging from condoms, contraceptives, HIV testing and treatment, and uninterrupted hormone treatment for transgender persons — are limited if available at all.

Shortages of medication have been reported around the world, with some countries already experiencing stockouts of SRH supplies. In South Africa, many SRH care clinics have closed or reduced their hours, while others have had to redirect human resources and clinic space to the COVID-19 response.

In addition to possible supply-side issues, lockdown might also restrict women's ability to access health care and SRH services. South Africa's repeat collection prescription strategies allow individuals to collect antiretroviral medicine refills from alternative pick-up sights to reduce hospital visits. However, fear of exposure to the coronavirus might discourage women from attending clinic appointments and seeking other SRH services. Reduced transport options during lockdown also disproportionately impact women, for whom walking carries a greater risk of assault.

One Khayelitsha resident told the *HSRC Review* how a visit to the local clinic meant that she and a friend had to walk home afterwards because no taxis would be operating for another four hours. Her friend, who lived even further away, ordered an Uber ride the rest of the way. "What if you don't have money?" she asked. Walking in Khayelitsha as a woman, she added, could cost you your life.

'Invisible' groups in an already overlooked area of health

Particularly marginalised groups are at risk of falling through the cracks in efforts to maintain access to SRH services and support.

LGBTIQ+ persons are confronted with the current crisis as a population already marginalised and lacking access to affirmative health-care services, where discrimination against sexual and gender minorities remains rife. Consequently, LGBTIQ+ NGOs are often their only access point for SRH services and support. Some clinics, such as the Wits Reproductive Health and HIV Institute (WITS RHI), have remained open, offering hope to transgender people — however, many have stopped accepting new patients and have reduced their clinic hours.

Joan, a transgender woman from Johannesburg, told the *HSRC Review* that she struggled to get an appointment at My Sexual Health, a clinic in the private sector, to have her hormone treatment implant replaced. "I was due to go in literally two weeks after lockdown started. I was so worried about it, because when I tried to arrange appointments before lockdown, it was just "No, we're booked full". She was fortunate enough to get one of the limited slots after lockdown started.

Others were not so lucky. Polite is a 39-year-old transgender woman who lives in Tembisa, Johannesburg. She had been trying to access gender-affirming services for nine years, but as a foreign national, she was not able to access free treatment from the public sector, and she could not afford it herself. Then, in 2019, she found the WITS RHI Trans Health Centre, which provides treatment regardless of nationality, and she was finally set to begin the process.

Now, however, due to lockdown, Polite and others who have not yet initiated hormone treatment, must wait. There is a long waiting list, she says. "This thing is now killing me because I don't know what to do … If I'm coming to the transgender clinic and I see the others [who have transitioned], I'll feel so disappointed in myself and so ashamed."

As a young adult, Polite struggled for years to express her identity in the face of rejection from family and friends, before she connected with the transgender community. School's Out, the HSRC's collaborative project with civil society organisations across the continent, has found that sexual and gender minority teens often struggle to access LGBTIQ+ organisations due to social stigma, and beliefs about what constitutes 'acceptable' and 'decent' youth sexuality and gender identity.

"When you're outside of the community, you have no one to talk to, no one to ask, and that makes it incredibly hard," Joan said. Lockdown makes attempts to travel to and from LGBTIQ+ clinics even more conspicuous, especially for those who cannot afford their own transport and must walk. Considering the extent of homophobic and transphobic police-perpetrated abuse, individuals face the further risk of violence from authorities enforcing lockdown.

In a context of high levels of sexual and gender-based violence against sexual minority women, access to services such as emergency contraception, abortion and counselling is critical. Many of these are time-sensitive services with dire implications if delayed.

These interwoven vulnerabilities speak to the need for an intersectional approach to mitigating the impact of the pandemic. Blanket approaches necessarily mean that the needs of those with identities and experiences that compound their vulnerability — such as sexual orientation, gender identity, age and nationality — cannot be appropriately attended to.

Note: Here is a list of GBV services provision across South Africa during lockdown, compiled by the Shukumisa coalition.

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BANNING ALCOHOL DURING LOCKDOWN:

It is not just about the virus or economics

The announcement of the total ban on alcohol sales in the days before the COVID-19 lockdown led to an alcohol rush hour as South Africans flocked to liquor stores to fill their trolleys. Drug-policy activists warned that the ban was dangerous for addicts and the Gauteng Liquor Forum, which represents approximately 20 000 mostly township-based shebeens and taverns, threatened to go to the Constitutional Court if the ban was not lifted. However, on 17 April 2020, President Cyril Ramaphosa announced the ban would remain in force for the duration of the lockdown. *Antoinette Oosthuizen* looks at research evidence on the devastating effects of alcohol on society that supports this decision.

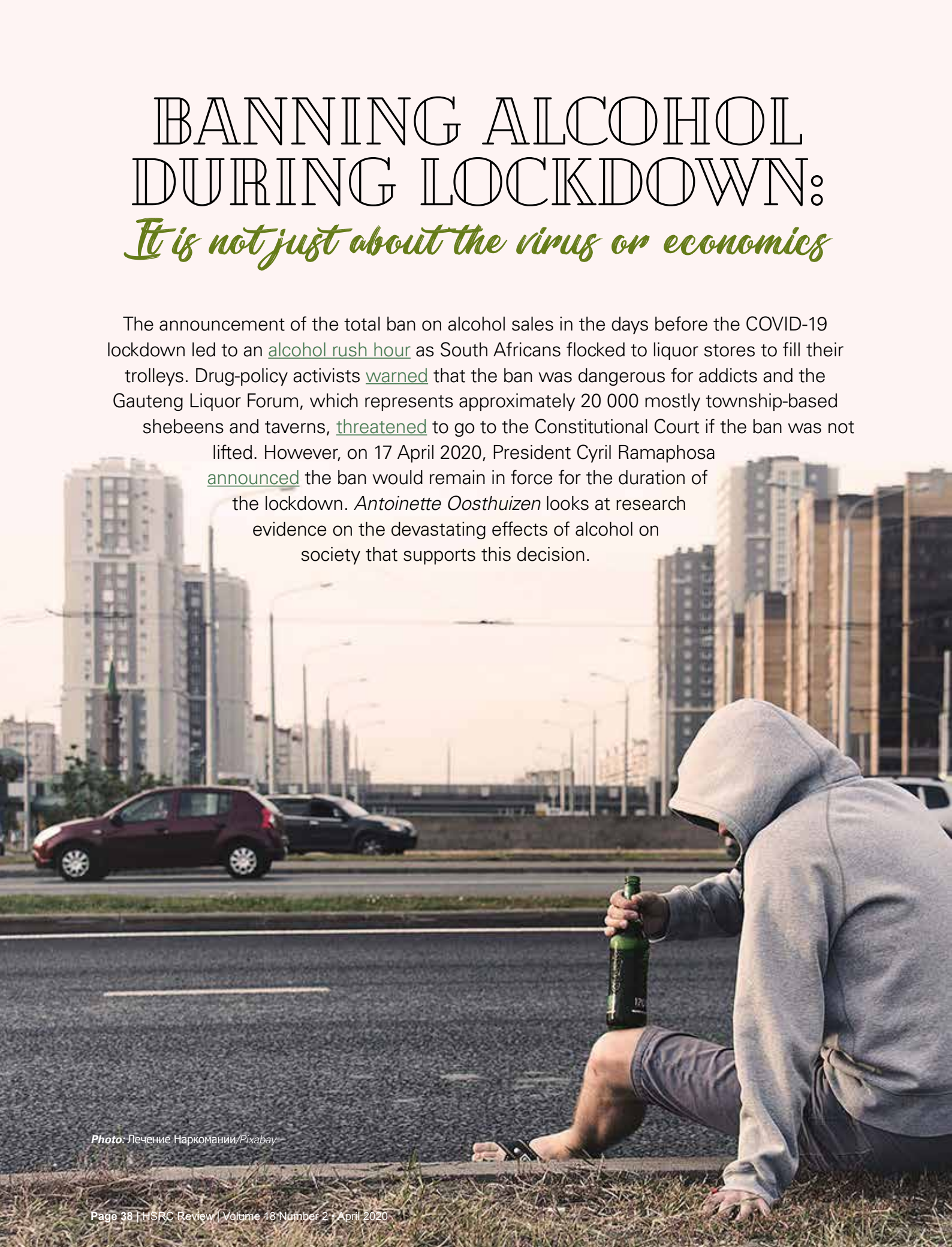

Photo: Лечение Наркомании/*Pixabay*

According to the HSRC's first South African National Health and Nutrition Examination Survey (SANHANES-1), which was conducted in 2012, 45.6% of households reported that they had drinkers, but the majority of the heads of households (61.3%) did not perceive the drinking in their homes as misuse of alcohol.

Yet, South Africans are among the riskiest drinkers in the world, according to the *Global status report on alcohol and health 2018*, published by the World Health Organization (WHO). Data from 2011 showed that the country had the highest reported alcohol consumption in Africa. Among those who consumed alcohol, 48.1% of men and 41.2% of women engaged in heavy episodic drinking. South Africans consumed an average of 9.5 litres each per year, substantially higher than the African regional average of 6.2 litres.

South Africa's road-traffic death rate (39.7 per 100 000 each year) was double the global rate, albeit not only due to drunk driving. An estimated 40% of road-traffic deaths in 2007 were of pedestrians, and over half of them had blood-alcohol concentrations above the legal limit.

According to the HSRC's SANHANES-1 report, the overwhelming majority of the household heads (83.6%) did not report violence or disturbances due to alcohol use in their homes. Yet, the South African Police Service crime intelligence unit reported in 2011 that with approximately 80% of murders, 60% of attempted murders, 75% of rapes and 90% of assault cases, the perpetrators had been under the influence of alcohol when they committed the crimes.

The researchers made the point that as the questions on alcohol were asked of household heads, perceptions of misuse, violence or disturbances may not have included incidences when the heads themselves had misused alcohol or were the perpetrators.

Data on binge drinking

In an attempt to quantify the prevalence of self-reported drinking and binge drinking, University of Cape Town researchers looked at data obtained from the 2014–2015 National Income Dynamics Study, a nationally representative dataset of just over 20 000 individuals aged above 15 years. Their findings, published in the *South African Medical Journal* in 2018, showed that one in three South Africans reported drinking alcohol and one in seven reported binge drinking on an average day of alcohol consumption. Alcohol use was reported by 33.1% of the population and binge drinking by 14.1%. Notably, more than 20% of men reported binge drinking and 6.4% of women.

The WHO also reported on several research studies showing elevated blood alcohol concentrations related to occupational injuries in mining, road accidents, domestic violence, murder, suicide, accidental deaths (such as falls, drownings and burnings) and risky sexual behaviour.

Citing a 2015 paper in *Alcohol and the Immune System*, Dr Charles Parry, director of the Alcohol, Tobacco & Other Drug Research Unit at the South African Medical Research Council, recently warned on social media that lung damage from heavy drinking might worsen the outcomes of respiratory infections. According to the paper, heavy drinkers are more likely to develop pneumonia, tuberculosis, respiratory syncytial virus infection, and acute respiratory distress syndrome, caused by an impaired immune response.

Trauma admission

Alcohol misuse, when combined with certain circumstances, culminates in a "perfect storm" with catastrophic results in hospital settings, wrote Dr Ernest Moore in an article published in *The Journal of Trauma: Injury, Infection, and Critical Care in 2005*. It impairs judgment and increases the likelihood of serious injury. An intoxicated patient is more likely to be hypotensive and less likely to be able to protect his or her airway, says Moore. They also have an increased chance of complications. He also said the management and evaluation of, and surgery on, intoxicated patients cost the health-care system more than sober patients.

Between December 2014 and February 2015, a team of researchers from the University of KwaZulu-Natal's Department of Surgery analysed 100 patients at the King Edward Hospital's trauma unit. They correlated blood alcohol concentrations with the severity of the patients' injuries, how they got injured, the length of their hospital stay and in-hospital mortality. Their findings showed that positive blood alcohol levels were associated with significantly more severe injuries. Injuries due to interpersonal violence were seen in 83 patients of whom 42 (51%) had positive blood alcohol. The hospital stay for alcohol-positive patients was also significantly longer compared to alcohol-negative patients.

A study at Groote Schuur Hospital in Cape Town, which looked at 9236 trauma admissions in 2010 and 2011, found a strong association between injury and alcohol use, with alcohol implicated in at least 30.1% of cases.

The WHO report stated that the harm per litre of alcohol was substantially greater for less affluent drinkers, citing a study that found 60% of all alcohol-attributable deaths occurred in the lower 30% of the country's socioeconomic distribution. A study in *BMC Medicine* estimated that one in ten deaths in South Africa was attributable to alcohol use in 2015.

The potential harm to addicts, including symptoms such as psychosis and seizures, and the risk of them breaking the law by accessing black markets to cope, would need to be weighed against these factors.

TEN DAYS INTO THE LOCKDOWN, EMERGENCY SERVICES OFFICIALS TOLD THE SABC THAT THERE HAD BEEN A STEEP DECLINE IN THE NUMBER OF TRAUMA-RELATED CALLS

Photo: *Alvin Leopold/Unsplash*

The impact of the lockdown

Ten days into the lockdown, emergency services officials told the SABC that there had been a steep decline in the number of trauma-related calls, particularly in relation to alcohol. According to a report by the Bhekisisa Centre for Health Journalism, an unpublished modelling study by Parry and his colleagues has shown that two thirds of an estimated 35 000 weekly admissions to hospital trauma units around the country have disappeared, including 9 000 of which would have been alcohol-related admissions.

In a media release on 22 April, police minister Bheki Cele provided crime statistics for the first 25 days (27 March to 20 April 2020) of the lockdown compared with the same period in 2019. Murders had decreased by 72%, rape by 87.2%, attempted murder by 65.9%, and assault with intent to inflict grievous bodily harm by 85.2%. Domestic violence, which included murder, attempted murder, rape and sexual assault, decreased by 69.4%. In most of the domestic violence incidents, the perpetrators were well-known to the victims and in a few cases, the murder was a result of an argument over liquor.

It could be said that these reductions were also influenced by the increased visibility of law enforcement, reduced traffic and reduced movement between areas during the lockdown. However, Parry and his colleagues have warned that lifting the ban during lockdown may lead to an increased risk of violence to women and children and the reappearance of just under 5 000 alcohol-related trauma admissions per week.

Economic versus social costs

Referring to the Gauteng Liquor Forum's threat to take the alcohol ban to court, economists told Fin24 that all sectors were struggling and the Forum would have to present a compelling argument for why liquor traders are an exception. On 14 April, the WHO advised against relaxing alcohol regulations during the COVID-19 pandemic. Three days later, President Cyril Ramaphosa announced that the alcohol sales ban would remain in force for the duration of the lockdown.

We have to weigh the economic costs of the alcohol sales ban against the social costs, says Prof Cheryl Hendricks, head of the HSRC's African Institute of South Africa (AISA). The institute conducted a study in Mpumalanga, which found that although alcohol sales provided some employment opportunities, it may not be worth the direct and indirect harm in less developed communities. Dr Palesa Sekhejane, who led the study, says community members told researchers that alcohol misuse was common practice, with children suffering the most from the indirect effect of it, mainly due to parental neglect.

But for how long do we keep the outlets closed? asks Hendricks. "What are the other things that need to accompany the alcohol ban during this time for it to have a lasting impact when we come out of the lockdown? If we do not consider that, we may be putting a *Band-Aid* on the deeper problem.

As Maurice Smithers, director of the Southern African Alcohol Policy Alliance of South Africa (SAAPA SA) writes in the *Daily Maverick*, the reduction in costs to the country of alcohol-related harm as a result of the lockdown ban is likely to more than offset the decline in revenue from excise tax. He suggests that surveys be done to determine the change in the quality of life of people living in communities that, before the lockdown, experienced challenges with liquor outlets operating in their neighbourhoods.

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MACROECONOMIC STIMULUS PACKAGES AND INEQUALITY IN DEVELOPING COUNTRIES:

Lessons from the 2007-2009 crisis for South Africa

The COVID-19 pandemic continues to spread relentlessly across the planet and has disrupted economic activities wherever it has spread. Rarely do health crises of this global magnitude result in such extreme macroeconomic destabilisation and devastation. Health and economic systems have been ill-prepared to counter the calamities of a pandemic of this scale. While lockdowns have been a chief instrument to protect weakened health systems from being overwhelmed by the pandemic, this immediate benefit pales against the escalating macroeconomic costs of this health crisis. The COVID-19 pandemic threatens to turn the global economic downturn into an extended Twenty-first Century Acute Depression, write *Dr Alexis Habiyaremye, Dr Peter Jacobs, Pelontle Lekomanyane* and *Olebogeng Molewa*.

Reflecting the country-wide halt of economic activity, the normally bustling Greenmarket Square in Cape Town is eerily quiet on the first day of the COVID-19 lockdown in March 2020.

Photo: *Discott, Wikimedia Commons*

Containing the spread of the COVID-19 pandemic is an immediate socioeconomic priority. In addition, countries urgently need appropriate fiscal and monetary interventions to limit the macroeconomic damage from these overlapping and compounding crises. Enormous mitigation measures coordinated across countries and multilateral agencies are unlikely to wipe out the losses suffered in the foreseeable future.

This scramble for new macroeconomic stimulus measures against the acute economic depression in almost all forecasts needs to consider lessons from past stimulus and recovery packages. Specifically, learning from the responses to the 2007-2009 Great Recession can help to avoid repeating some of the mistakes observed in many developing countries during the subsequent recovery period, which exacerbated social inequality and failed to lower unemployment.

Great Recession (2007-2009) insights

When the 2007-2009 global financial crisis erupted and threatened the global economy with a gigantic shock, most advanced economies devised unprecedented fiscal and monetary interventions to stabilise their markets and avert the worst consequences of a possible meltdown. The intricate nature of the globalised production and trading systems propagated the crisis to developing countries through massive financial outflows and a sharp reduction in the prices of and demand for natural resource exports.

For many developing countries, especially the resource-dependent non-oil exporters, the ensuing food price inflation shocks pushed 100 million people into poverty. Consequently, many developing countries had to roll out fiscal and monetary policy measures of their own to stabilise domestic markets and cushion their economies from exogenous shocks. Most observers agree that

such interventions enabled those economies to recover more rapidly than they would have without stimulus.

Macroeconomists disagree on the content and composition of stimulus packages. In the Great Recession, this disagreement pivoted on a fundamental question: should governments use tax payers' money to bail out large banks and powerful corporations at the expense of the working poor? Contrarians won this dispute as evidenced in the weak economic upturn and rapid rise of corporate bankrupt filings in the post-bailout years. Unsurprisingly, the sluggish recovery failed to counter rising inequality and poverty, with food and nutrition insecurity and economic exclusion reaching new heights.

South Africa is often lauded for the way it handled the Great Recession. Because of its pre-crisis policies that favoured expansive spending, the government was well positioned to deal with the 2007-2009 financial crisis and is generally credited for the adequacy of its fiscal and monetary response. Despite all these prudent measures, however, there were massive job losses resulting from the onslaught of the crisis on the South African commodity sector, employment has not recovered and growth has remained sluggish in the recovery period.

Macroeconomic agenda against poverty and inequality

All the evidence indicates that the COVID-19 economic meltdown will be closer to the Great Depression (1929-1933) than the Great Recession (2007-2009) in its severity, pervasiveness and endurance. This calls for anchoring macroeconomic responses firmly to the needs of poor and vulnerable households.

After all, these households ultimately bear a disproportionately large burden of economic slumps, as they lack the resources to counter the resulting livelihoods crises. The way in which they cope with the consequences of economic downturns creates social costs that often translate into aggravated inequality. In developing countries without adequate safety nets, such distributional effects usually go hand in hand with increased incidence of poverty, as cautioned by the International Labor Organization.

Prioritising investment in deliberately pro-poor macroeconomic stimulus packages is urgent but does not yet exist. What does this mean for orienting the facets, mechanics and outcomes of fiscal and monetary stimulus interventions? Against exclusionary fiscal and monetary policies, the focus ought to be on sustainable and active economic participation, first and foremost. A pro-poor macroeconomic stimulus agenda must prioritise employment and growth recovery, the distributional effects on inequality and poverty and the trade-offs between bailing out corporations versus supporting household purchasing power.

Pro-poor macroeconomic stimulus to counter the economic downturn is a vital immediate response but not sufficient for constructing a post-COVID-19 society. Strategic responses ought to include instruments and resources to carry out the structural changes needed to give shape to that new human society. For this reason, macroeconomic responses to the current pandemic need to be designed in such a way that they contribute to laying the foundation of the post-Covid-19 economy, which ought to be engineered as more equitable and more responsive to the needs of local communities, and therefore more resilient to external shocks. Building an equitable society must be at the heart of the structural macroeconomic policy South Africa needs now.

To avoid a response that could prolong the crisis and leave the high rate of unemployment unchallenged, it is necessary to adopt a comprehensive strategy involving multiple stakeholders, whereby the government partners with business sectors to tackle the persistently high unemployment rates as part of the country's societal crisis to be solved. For a multi-stakeholder strategy to emerge, it is necessary that social scientists and macroeconomists in our society engage in macroeconomic policy dialogues, so that out of their multiple theoretical approaches, a judicious choice can emerge and guide the national strategy to come stronger out of the current calamity. That is why the Inclusive Economic Development division of the Human Sciences Research Council is launching its flagship programme "Macroeconomic Policy Dialogues", with the objective of bringing together social scientists and economists of different persuasions to stimulate alternative macroeconomic analytical approaches that enhance the quality of policy recommendations for South Africa.

In the first two years of the Macroeconomic Policy Dialogues programme, the HSRC will be a catalyst that promotes evidence-informed conversations about designing, strengthening and implementing pro-poor macroeconomic policies. Grounded in the principles of transformative participation and constructive interaction, the programme will exploit multiple communication platforms. Towards this end, the HSRC team spearheading this initiative is busy strengthening networks with representatives from the policy arena, research communities, civil-society formations and business enterprises to optimise their active involvement.

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The need for universal health care: What COVID-19 may teach us

The global spread of SARS-CoV-2, which causes COVID-19 disease, has caused an international standstill as nations face the true test of their health-care systems. South Africa's National Health Insurance (NHI) system is only set to come into effect in 2026 but, in the interim, the country needs a strong and collaborative national response by the private and public health-care sectors to contain this pandemic.

By *Prof Narnia Bohler-Muller* and *Nokuthula Olorunju*

Mitchells Plain Hospital where a COVID-19 testing and triage centre has been set up

***Photo:** Western Cape Government*

The COVID-19 pandemic has brought South Africa face to face with the harsh realities of a two-tier system of health care that protects the wealthy and leaves the majority of South Africans at risk. In 2008 and 2009, there were 3,533 ICU beds in private hospitals serving 20% of the population and 1,186 in public sector hospitals serving 80% of the population. This is according to an article by Dr Tom Boyles, an infectious diseases consultant at Helen Joseph Hospital in Johannesburg. The same figures were reported in a 2013 article in the *South African Medical Journal* and a 2019 article in the *Southern African Journal of Critical Care*. In the latter, researchers warned that South Africa faced significant resource shortages in terms of ICU bed numbers compared with high-middle-income countries, especially in state hospitals. There was also a shortage of trained nurses and intensivists and insufficient data evaluating resource provision.

A recent article, based on a health department presentation in April 2020, reported South Africa had 3318 critical-care beds available of which almost two-thirds were in the private sector. It also had 2722 high-care hospital beds available (60% in the private sector). But COVID-19 entails ventilator care, and the country had only 3216 ventilators instead of the needed 7000. Only 1111 of those were in state hospitals.

With public sector ICUs already at full capacity, a large COVID-19 outbreak would put an immense strain on services and many poor patients would be left behind in the struggle to survive, Boyles warned, adding that COVID-19 would bring inequality into sharp focus.

Vulnerable communities

By 28 April, South Africa had 4793 COVID-19 cases and several in large townships where the poor have no medical cover to protect them.

It is clear that the virus does not discriminate, but due to the current state of poverty and inequality, the poor will suffer the most if the spread is not contained:

> "If the worst happens, and there is a large outbreak affecting rich and poor communities alike, we will see an enormous strain on health services which will bring inequalities between the haves and the have nots into sharp focus. Although tragic, at the same time it would illustrate why South Africa desperately needs the National Health Insurance bill," wrote Boyles.

In developed countries, the strongest predictors of death from COVID-19 are advanced age and comprised immune systems. If there is a major outbreak affecting all communities in South Africa, the strongest predictor of survival will be "access to medical insurance and therefore an ICU bed", according to Boyles.

An increased NHI focus

While media coverage has centred predominantly on COVID-19 causing more strain on the public health-care system in South Africa, there is increased consideration of how the cooperation and coordination of the public and private health sectors and the proper allocation of funds would be of benefit to the poor and most vulnerable. South Africa's NHI system is only set to come into effect in 2026, if the legislation is passed after further consultations take place once Parliament reconvenes. While the NHI is not explicitly mentioned, there is a more pointed focus in media coverage on the principles and provisions contained in the Bill (11 of 2019), especially related to a nationally coordinated response to health-care needs.

Lessons from abroad

The biggest global lesson of this pandemic is the need to establish an effective public health-care system that does not discriminate on the basis of race, class, beliefs, origin, or gender. For South Africa to implement an effective NHI system, the state must learn from the triumphs and challenges faced by other nations.

A frightening lesson has arisen from a country that has been virtually decimated by the virus. The northern part of Italy, which has seen the highest number of cases, is facing the collapse of their health-care system. According to an article by Italian researchers in *The Lancet* in March, the country's health-care system, which is based regionally and run by local governments, has over the past decade suffered severe financial losses. This was due to inadequate strategic leadership, fragmentation, increasing privatisation of national health-care services and the lack of resources.

Similar results are evident in many other European countries, leading to Ireland and Spain nationalising private hospitals and various governments struggling to meet the needs of an increasingly vulnerable populous. In the US, where deaths are predicted to exceed 200 000, individual states are competing for ventilators and other medical equipment in the absence of strong leadership and a centralised response to the virus.

A need for strategic leadership

Following the declaration of a national disaster according to section 27 of the Disaster Management Act, 2002, EFF opposition leader, Julius Malema stated that:

> "We also call upon the private hospitals, that the only way to avoid nationalisation of those private hospitals is by fully co-operating with the minister of health when he needs beds for our sick people. It's not a time to make a profit."

It has become increasingly clear that health care requires a strong national response, not only when faced by pandemics, but to ensure the health of all and access to health care by all. The crucial integration of public and private entities in all sectors, and particularly the health-care sector, is apparent. Media coverage has focused on the numbers and the graphs, but commentary is also trending towards a focus on the importance of the rights to health-care, equality and dignity.

South Africa urgently needs an effective universal health-care system. Such a system, and by extension the NHI, must avoid fragmentation and promote social solidarity. The institutionalisation and coordination of the public and private health care sector is central to an effective system. Consistent, strategic, accountable, transparent and decisive leadership is vital.

Coming to the table?

On 30 March, the Netcare Group said in a media release that its private hospitals had suspended non-essential elective surgery, closed its hospital pharmacies to the public, and had proposed to the national and provincial Departments of Health that they would treat public patients in Netcare facilities. "Given the exceptional circumstances and to ensure sustainability, Netcare will provide these services to COVID-19 related patients on a not-for-profit basis, seeking only to recover costs," said the group's CEO, Dr Richard Friedland. Netcare clarified that, given its hospitals' limited capacity, referrals from the public sector "will need to be assessed and pre-authorised by Netcare on a case-by-case basis".

South Africa has not seen the worst effects of this pandemic, and it remains to be seen how cooperative the private health-care sector will remain when faced with the 'masses' who cannot pay and have no private medical aid protection.

Social solidarity will become even more crucial, with all sectors willing to collaborate and give, and perhaps also to sacrifice the privileges enjoyed on the fortunate side of the country's two-tiered health system.

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Connected Lives

Families, households, health and care in contemporary South Africa

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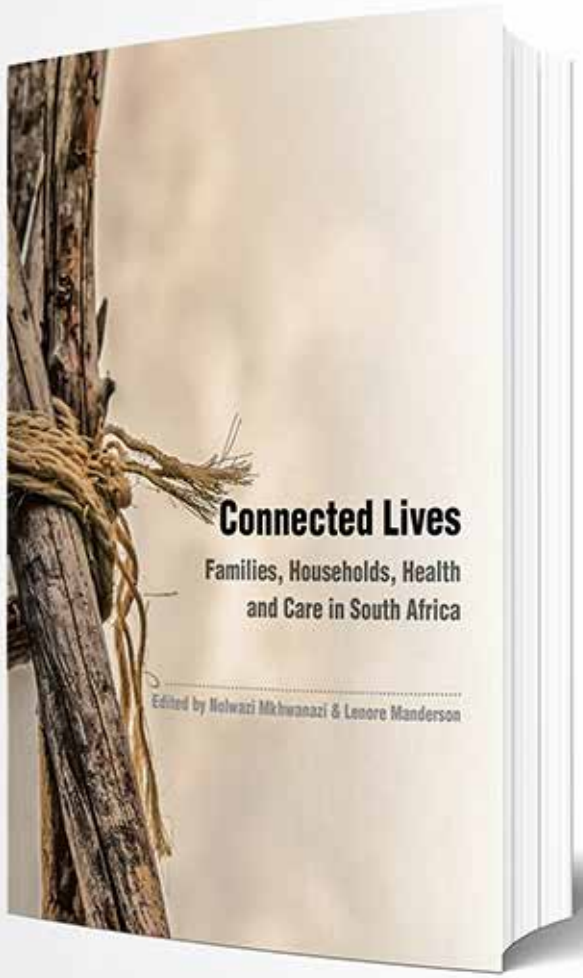

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ABOUT THE BOOK

Connected lives: Families, Households, Health and Care in South Africa explores the household as a site for the production of health and care. This volume illustrates the changing constitution and the variability of households, fluid understandings of family, and the impact of these in the context of life changes and health problems.

Through 29 case studies of people of diverse backgrounds in terms of ethnicity, class, sex and gender, of varying ages and from urban and rural backgrounds, *Connected Lives* considers how these factors influence everyday life, health, wellbeing and care in contemporary South Africa.

This book will interest those in global public health, anthropology, psychology, sociology, community health, population and demography studies.

INFORMATION ABOUT AUTHORS/EDITORS (BIOGRAPHICAL)

Lenore Manderson is a distinguished professor of Public Health and Medical Anthropology in the School of Public Health at Wits, with affiliations with Brown and Monash Universities. Her research and publications focus on chronic and infectious disease and social circumstance, with attention to how access to technology unequally interacts and impacts on chronic conditions. She also works on questions of climate change, adaptation and advocacy.

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Opening the South African Economy

Barriers to Entry and Competition

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ABOUT THE BOOK

What does it take for entrepreneurs to be effective competitors? What are the factors affecting entry and participation in sectors where there are historically strong incumbent firms? *Opening the South African Economy* brings to light the challenges of concentration, inequality and exclusion in different sectors of the South African economy.

The book begins with an assessment of the current state of the economy. Detailed case studies then recount the experiences – good and bad – of well-known South African entrant firms in sectors that are critical for facilitating economic growth, including retail, food, fuel, telecommunications, airlines and banking. Important cross-cutting chapters reflect on the role that government policies can play in achieving a more open, inclusive and competitive economy and the use (and misuse) of policy tools such as competition law, black economic empowerment and state procurement. It concludes with a set of concrete recommendations for opening up the South African economy, improved coordination among state institutions and inclusive industrial development.

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' … a timely review of South Africa's journey to opening up markets … '

– **Mondo Mazwai**, *Chairperson, Competition Tribunal of South Africa*

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