ROUNDTABLE:

ONE SIZE DOES NOT FIT ALL: COVID-19 RESPONSES ACROSS AFRICAN SETTINGS

26th May 2020

There is growing recognition of the need for responses to the COVID-19 pandemic to be attuned to their national and local contexts if they are to be effective and socially just. In diverse African settings, it is increasingly clear that the models of preparedness and response applied in Asian and European countries might be inappropriate or require local adaptation – and that strategies and approaches are needed which suit particular health, social, economic, demographic, political and historical conditions and experiences, and state-society capacity and relations. There is less clarity on what this range of alternatives looks like, and how they might be implemented. This roundtable convened social science and public health researchers and practitioners working on COVID-19 preparedness and response in African settings. The discussions from this roundtable were linked to an Africa CDC-led webinar the following week, which focused on the challenges related to the easing of stay-at-home orders. In this report, we present areas of debate and contention and report on key themes identified in the roundtable, including viewpoints from Sudan, Kenya, and South Africa.

KEY DISCUSSION POINTS AND EMERGING QUESTIONS

- There are multiple uncertainties and ambiguities in the data related to COVID-19 and what it means in terms of evolution of the pandemic and the impact of the response.
- Is a 'one-size fits all' approach to lockdown appropriate in African countries? What are the consequences - for health, livelihoods, and for the economic health of nations and their most vulnerable?
- How effective are top-down approaches to pandemic response? What is the role of partnership and collaboration between governments and civil society? Is there space to work together to design and implement proportionate, localised control and mitigation measures?
- A number of states are engaging in a disciplinary approach to public health response compliance. Some states appear to be using public health as a smokescreen to cover ongoing persecution of marginalised groups, such as informal settlement residents. How Is the response being politicised?
- The COVID-19 response has exacerbated and laid bare existing health, social and economic inequalities. The most vulnerable are most at risk of loss of livelihood, secondary health impacts and food insecurity.

- Trust in the response could deteriorate as economic insecurity increases and if dialogue with citizens is inadequate. How can governments and citizens best communicate transparently, and provide justification for particular control measures and what the long-term plan is?

COUNTRY CASE VIEWPOINTS

The roundtable included perspectives from three countries as example viewpoints of how COVID-19 measures have been implemented and affected by contrasting national and local contexts in three countries: Sudan, Kenya, and South Africa. These viewpoints are not generalizable, nor do they contend to represent the full range of on-the-ground perspectives. Rather, they serve as an illustration of key themes in the COVID-19 response on the continent. Presenters discussed the following key questions:

(1) What response measures have been implemented, who are the key players, and is there coordination of efforts?

(2) How is the response interplaying with local social, livelihood and political conditions?

(3) What opportunities exist to build local responses and what experiences might these draw on?

Sudan (viewpoint presented by Nada Abdelmagid – LSHTM)

The Sudanese government reacted swiftly to the COVID-19 pandemic, closing learning institutions and implementing border restrictions the day after the first case was recorded. A strategy of finding, isolating, treating and tracing cases was implemented. Over the next month, in-country travel and gatherings were banned, curfews were put in place, and Khartoum was placed under lockdown. There are concerns that response may be overly medicalised and erroneously focused on containment, since there is widespread community transmission. The government has engaged in risk communication, but with one-way information sharing. With widespread mistrust in government information, misperceptions about the virus abound.

Several non-state actors have contributed to the response, including the private sector and military, NGOs and civil society and the Sudanese diaspora; however, the contributions of youth in communities has been the most visible and remarkable. These groups have contributed in various ways, from supporting the medical response to providing social and economic assistance. There seems to have been insufficient coordination between the state and civil society.

The general public, already faced with an unstable economic environment, does not have the capital to cope with prolonged movement restriction. The transitional government has provided welcome social protection measures to vulnerable households, but these are deemed not to be enough. Restrictions were due to be lifted on May 30th but have been extended until June 18th and there appears to be no exit strategy. There are opportunities to capitalise on the social tendency among communities to support each other and protect the most vulnerable, although stigma toward families with COVID-19 has the potential to override this tendency.

Kenya (viewpoint presented by Joseph Kimani – Muungano Alliance, SDI Kenya)

Public health response measures in Kenya have included school closures, curfews and movement bans. Targeted mass testing has been carried out, alongside quarantine of suspected cases and isolation of patients in designated wards. There has been mass sensitisation on COVID-19 preventive measures. Civil Society Organisations (CSOs) and Community Based Organisations (CBOs) have been complementing and, in many cases, appear to be acting faster than government. The government has established task committees in which citizens are actively participating. CSOs are also disseminating information through posters and social media, and providing handwashing stations, sanitisers, PPE, food aid and cash transfers. CBOs in informal settlements have raised funds to set up water stations and distribute soap and food to vulnerable people. Youth groups are collecting garbage, and savings groups have bought food for those in need.

Supported by several partners, Muungano wa Wanavijiji (Slum Dwellers Federation – SDI) has initiated the development of a tool to gauge the level of community preparedness to adapt to government guidelines, and identify gaps and priorities for each community. Community-led data collection is being carried out in 120 villages in 4 counties, and close to 15,000 interviews have been undertaken. Weekly reports are produced and shared with communities and other partners, who are using the data to inform their actions. Recommendations to have come out of the data include better coordination between the government and CBOs, better inclusion of young people as Community Health Volunteers (CHVs), and an end to police violence related to public health measures. Muungano has used the data to provide the Ministry of Health with maps indicating possible isolation areas and required handwashing facilities.

Movement restrictions have created economic hardship for residents of informal settlements, and at the same time case numbers are increasing in these settlements. Current restrictions are due to be relaxed on June 6th, which may bring some relief, but there are concerns as to how those in informal settlements will be protected from the virus after that time.

South Africa (viewpoint presented by Andries du Toit- Institute for Poverty, Land and Agrarian Studies, PLAAS)

South Africa responded to the pandemic by rapidly declaring a National State of Disaster on March 15th, followed by a stay-at-home order and a rapid roll-out of a community screening, testing and tracing programme. The government carried out effective two-way risk communications via regular public briefings and a department of health WhatsApp channel. An evidence-based and regionally differentiated pathway out of lockdown has been designed. While the swift actions of the government have been commended by the WHO, the response has been criticised by some as largely top-down and largely led by biomedical perspectives, encouraging a disciplining of citizens by state actors enforcing measures, . Regulations have sometimes appeared difficult to understand, such as those that discriminate against foreign informal workers, curfews and the prohibition of sale of certain items in shops. The police and defence force have exercised brutal, sometimes lethal, force against poor and black citizens.

There has been a focus on civil society responses to mitigate the economic effects of lock down. There has been less focus on mobilising community-level capacities for self-organisation for community health. Experience from HIV/AIDS has taught that an effective response requires a partnership between the state

and civil society, and must work at two levels: individual self-care and care of other community members; and a broader state and biomedical response. South Africa's approach is built on the assumption of an effective state that has access to current and reliable data, and that engages with a formal economy and a compliant and trusting citizenry. In reality, conditions of poverty, informality, a lack of reliable data, and strained relations with an often-mistrustful citizenry come together to make the mobilisation of community-level capacity all the more important.

The lockdown has disproportionately affected those who live precariously and depend on the informal sector. Millions are experiencing food insecurity due to the shutdown of the informal economy. The South African government has made resources available through social protection measures, but the amounts are not enough, and implementation is problematic. The current response has the potential to significantly increase poverty and malnutrition and to deepen economic inequality. It may also increase political polarisation, and endanger the social legitimacy of the response.

Summary of Country Case Studies

Most African countries implemented measures swiftly. The recorded burden of disease and deaths has been less than in Europe, although the reasons are debated and might include age profiles, immunity status, and under-recording as well as early containment measures. However, the rapid response came at the expense of considered plans to address the feasibility and potential social and economic impacts of lockdown. In all three spotlight countries, the resulting economic emergency may even be a greater threat than the virus itself. Economic relief measures that favour the formal sector are exacerbating the already precarious situation of informal workers. Social protection measures put in place are not enough or are limited by state capacities. The question is how to continue to respond to the threat of the virus in a way that is proportionate, whilst gaining stability and ensuring social justice and equality. The examples also highlight the importance of context-specific responses. Governments need to be alive to the populations that have tended to be invisible to them, including those in dense informal settlements with specific characteristics and needs.

In all three examples, there appears to be scope to strengthen the relationship between civil society and government. Experience shows that responses work better when communities are organised, and when there is collaboration with CSOs. Of note is the role of youth, who were highlighted in the examples of both Sudan and Kenya as an invaluable and untapped resource in interventions, and in communicating between different parties. Engaging with local populations and harnessing local capacity can lead to a more effective and ethical response.

THEMATIC SUMMARY OF OVERALL DISCUSSION

One Size Does Not Fit All

- Most countries reacted quickly to the pandemic instituting measures when caseload was low. Risk mitigation measures have been similar across the continent, following international guidelines and combining different elements of movement restrictions, lockdowns and testing, tracing and isolation, together with some social protection and livelihood support. Hasty implementation in some cases has meant less clarity on inequalities in socio-economic impacts, and lack of clear steps towards easing the lockdown.
- Implementation measures have been 'imported' from countries which have different age and health profiles, health systems and social protection capacities, often built upon predictive models that ignore variability in different contexts.
- The diverse social, political and economic dynamics have made the plausibility and adequacy of measures vary (as well as their on-the-ground implementation), depending on country and local context, and migratory movements. The ability to follow guidelines is shaped by the context people live in: urban or rural settings, poorer or wealthier contexts, type of settlement and housing, and other political and social differences. Local needs and circumstances should be incorporated into the response.
- Different priorities vis-à-vis COVID19 will vary according to country and context. There are many other health priorities such as other locally prevalent contagious and chronic diseases. Needs for food and income for survival are critical amongst people living precarious livelihoods. Such priorities must be balanced with priorities around controlling COVID-19.

Top-Down Approaches and Community Engagement

- Participants expressed concerns that in some countries, COVID-19 responses have been top-down, designed and implemented by national governments and national task forces. Participants highlighted that top-down approaches have been driven by narrow biomedical perspectives and a 'politics of the moment' that privilege COVID-19 concerns over other health needs and social and economic impact.
- A top-down approach ignores the reality that public health is a social good that is co-produced by the state and civil society acting together. It assumes particular capacities of the state and particular kinds of governance and state-citizen relations. The stay-at-home orders that have been mandated across the continent would assume that the government can provide for its citizens through social protections to mitigate social and economic harms. Unfortunately, this has not been the case.
- Participants discussed alternative strategies to bolster community engagement and build multitiered coalitions to improve buy-in and public confidence in the response. Alternative strategies like shielding or test, treat, and isolate can be considered. Community-driven strategies can tailor top-down approaches to the complexities of various communities. Communities should also be given more authority to mandate public health control measures in their jurisdiction.

Discipline and State Control

- A top-down approach, when led by an authoritarian government, can lead to unnecessarily complicated and disciplinarian approaches that go beyond immediate public health concerns. Participants expressed concern that some states are engaging in a punitive approach to public health response compliance.
- The example of South Africa raises concerns about potential negative long-term consequences for democracy and development. Within the proliferation of complex public health regulations, the state has imposed bans on smoking and the sale of alcohol, has instituted curfews without clear public health reasoning, and has acted in ways that are likely to consolidated corporate concentration and control and further marginalise the informal sector.
- Mandates have been unevenly implemented, and informal settlement residents have been disproportionately impacted by policing efforts to enforce public health regulations. This inequitable enforcement raises questions of what kinds of modalities are undermining citizen trust in the response.

Social and Economic Inequalities

- The COVID-19 pandemic has both laid bare and exacerbated inequalities. As stay-at-home orders continue in some contexts, informal workers and other low-wage workers are at most risk of additional economic insecurity, food insecurity, and loss of housing, while formal sector organisations and large multinationals have often acted swiftly to exploit new economic opportunities.
- Social protection schemes in many countries may have already been insufficient prior to the pandemic, and additional schemes are insufficient to address the impact of lockdown measures. There are evident discrepancies in some cases between government commitments and implementation on the ground. Social protections are falling short, especially for societies' most vulnerable populations, who were already facing economic insecurity. How can governments, given limited resources and limited capacities, fulfil their obligations as much as possible?

Trust in the Response

- Trust in the response is shaped by political and social histories between affected citizens and the State. This may be a relation of marginalization and neglect, particularly towards the poor, informally employed, people living in informal settlements, migrants or other vulnerable communities. In some countries, measures have been implemented through state violence and other forms of coercion.
- Other sources of mistrust towards the response relate to the lack of first-hand evidence of the disease in less affected areas, poor communication, and the circulation of fake news. People may justifiably distrust responses that may make them destitute when the reasons are unclear to them. The unfolding of the pandemic and the economic fragility as a result of public health measures will shape trust.
- Community feedback data gathered by the IFRC and rapid research by international organizations have shown a lack of adequate information and high levels of misinformation circulating, with people not having clarity over how to adhere to guidelines. As the pandemic has developed, an increase in mistrust

towards government and other responders has been reported. Mistrust is also shaping people's willingness to seek medical help.

- Conventional risk communication though traditional and new media should not be the only mode of communication. It should be paired with more comprehensive messaging, two-way communication, and long-term community engagement. Using local languages and enlisting local allies such as community youth leaders, community health workers, or neighbourhood associations for communication has proved useful.
- Transparency is key to generating trust. This includes: making a clear case for lockdown measures or alternative measures when relevant; stating honestly what is known and not known; managing expectations and, explaining the scientific basis and steps for easing of lockdown, as well as long terms plans for the economy and health provision.
- Fear, uncertainty and misinformation, and different levels of exposure to the disease, have led to stigmatisation, exacerbating already existing dynamics of oppression and discrimination. The response itself, in targeting particular people and framing the disease and its transmission in particular ways, can be responsible for generating stigma. Groups affected by stigma include health workers, households of people who have tested positive to COVID19, people in quarantine, and people or social groups perceived to be responsible for transmission of the disease (e.g. Muslims in Kenya singled out for washing bodies in funerals).

Getting the Right Data

- The systems of information used by health systems and other public bodies are inadequate to draw a 'realistic' picture of the number of people who are infected, develop symptoms, are treated and recover or die from COVID19. For example, hospital record entries may be inadequate or not available digitally, or deaths may be misallocated. The symptomatology of mild and moderate symptoms also overlaps with other common infectious diseases in the region. It is also difficult to monitor different kinds of populations' needs and resources to aid livelihood support.
- Integrating community feedback gathered at a local level (gathering questions, perspectives and needs, as well as suggestions for response activities) into the response allows for a granular understanding of the social aspects of the pandemic. This information must be used to initiate dialogues with state, civil society, communities and other stakeholders in the response.
- The example of SDI in Kenya shows how when grassroot communities are organised, reliable local data can be gathered on their specific needs and resources, as well as providing locally-relevant and actionable information to both those communities and decision makers. Dialogues based on this data enable localised response measures rather than blanket implementation of national guidelines.

Emerging Issues and Questions

- The discussion highlighted the need for learning about positive coordination and collaboration between states and civil societies, both ongoing during the COVID-19 pandemic and from past experience.
- The existing information systems in affected countries do not enable a full picture of both the epidemiological and social aspects of the pandemic. When aiming to localise the response, how can we build on grassroots and bottom-up initiatives to get a clearer granular understanding of the disease and its impacts? How can we bring in different perspectives and knowledges?
- In some countries there has been a politicisation of the response, with heavy-handed responses and some leaning towards repressive authoritarianism. The framing of the pandemic and its mitigation measures are being politicised by different social actors across different lines, including political parties and ethnic groups. Misinformation is being circulated to advance interests or to create suspicion. How do we understand these processes of politicisation? What can be done about them to promote a fairer COVID-19 response?
- Trust in response appears to be steadily declining as the pandemic unfolds. It is important to situate trust in the social and political histories of the areas affected, and it is also important to see how trust changes in the shorter-medium term as the epidemic unfolds. What evidence is emerging to understand the factors that shape trust: e.g. communications, coercive/cooperative approaches, exposure to COVID19 cases, experience of other epidemics, and so on? What examples emerge of successful trust-building or undermining of trust?

CONTACT

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or (oliviatulloch@anthrologica.com).

The Social Science in Humanitarian Action is a partnership between the Institute of Development Studies, Anthrologica and the London School of Hygiene and Tropical Medicine. Funding to support the Platform's response to COVID-19 has been provided by the Wellcome Trust and DFID.