JOURNAL AIMS AND SCOPE

Social and Health Sciences (formerly the African Safety Promotion: A Journal of Injury and Violence Prevention) is a multidisciplinary forum for critical discussion and debate among scholars, practitioners, activists, students and policymakers whose interests and work intersect with the social and health sciences. The journal welcomes theoretical, empirical, applied and policy submissions on such topics as: violence in its multiple forms, injury, health and safety promotion, community engagement, epidemiology, health economics, health systems research, structural and social determinants of health, and knowledge production in the social and health sciences. While based in Africa, Social and Health Sciences invites submissions from the broader Global South, as well as the Global North.

SUBJECT COVERAGE
Issues of Social and Health Sciences’ predecessors addressed a variety of injury and violence related topics, such as:

• Critical social perspectives to injury and violence prevention
• Injury surveillance methodologies
• Costing techniques
• Epidemiological research findings
• Health systems research
• Risks and resiliences associated with violence and injuries in low- to middle-income contexts
• Best practices for injury prevention and containment

Social and Health Sciences is an accredited South African Post Secondary Education (SAPSE) journal. All articles in the journal are subject to peer review. Social and Health Sciences is published biannually and features original full-length articles, theoretical papers, reviews, commentaries, reflections, and short communications.

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Acknowledgements
Impacts and Responses to COVID-19: Perspectives from the Global South

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A REFLECTION ON THE PRESENT CONJUNCTURE

This inaugural Special Issue of Social and Health Sciences enters into, and thus must also speak to, a world which increasingly demands transformative social change. Therefore, before we describe the renewed scope of the journal and the contents of this Special Issue on COVID-19, it is worth offering a brief reflection on our present conjuncture.

It is perhaps a banality at this stage to note that the pandemic is a political concern inasmuch as it is a public health priority. The almost 1.5 million deaths from COVID-19 thus far - not to mention the millions of infections - were not inevitable, and correlations have been drawn between the kinds of government measures implemented and the variable rates of infection (see Watkins, 2020). Health guidelines and government orders which responded to COVID-19 have ushered in secondary effects which have profoundly changed people’s lives. Indeed, national and international economies are said

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to be in a more dire state today than they were during the 2008 global recession. Rates of unemployment have risen rapidly all over the world and the psychological strain that people are experiencing is being compounded by their material struggles (Fisher et al., 2020; Khan, Ratele, & Arendse, 2020; The Lancet, 2020). Poor and working class people who could either not afford to stay away from work - and have thus been made to labour in unsafe conditions - or who have lost their jobs altogether, have been hardest hit by the pandemic (Davis, 2020; Dean, 2020). In many places, marginalised populations are being exposed to appalling levels of police brutality (see Farge, 2020), both in the guise of lockdown enforcement as well as through white supremacy’s increasingly violent functioning (Dean, 2020; Ratele & Malherbe, 2020). Women have frequently been burdened with taking on the extra care work that is now being required (Fisher et al., 2020; Malherbe, 2020), with alarming rates of gendered violence also being recorded (Kofman & Garfin, 2020). On the other side of all of this, billionaires, like Amazon CEO Jeff Bezos, have seen considerable profits as a result of the pandemic (Dean, 2020). We are, in short, seeing what can be understood as a kind of corona capitalism (Žižek, 2020), which has seized upon, aggravated, and even profited from already widening social inequalities (Malherbe, 2020).

State violence in the era of COVID-19 has, however, not gone unchallenged. This reached a fever pitch in the mass protests against the police murder of George Floyd, an unarmed Black man in the United States (Ratele & Malherbe, 2020). Protesters have since gathered all over the world to reject a range of issues, such as police brutality, draconian laws on abortion, and authoritarian regimes. With respect to COVID-19’s exacerbation of the global crisis of care (see Malherbe, 2020), we are also seeing strike action against institutions that are prioritising profit-making over people’s livelihoods (Cheng, 2020; Harris, 2020). Added to this, several community-led mutual aid initiatives are responding, at the grassroots level, to inadequate government measures which have been taken against the pandemic (Davis, 2020; Sitrin & Colectiva Sembrar, 2020). Cooperation, it would seem, is proving crucial across these various resistance efforts (see Žižek, 2020), and although there has not, in recent memory, been a riskier time to gather and resist, there has also not been a more urgent moment to do so. As Jodi Dean (2020, p. 45) notes, “thousands of people were willing to risk their lives in the struggle against the racist capitalist system ... Between the virus and the economy, there was nothing left to lose. And there is a world to win.”

The official response to the pandemic has, in large part, been led by public health experts, especially through behaviourally-based prevention strategies. Social scientists and researchers have also made important interventions here, and have sought to interrogate the socio-political antecedents and valances
of the virus (e.g. Davis, 2020; Fisher et al., 2020; Khan et al., 2020; Watkins, 2020). However, it has been the work of doctors, nurses, and healthcare workers that has allowed others to physically distance (Žižek, 2020). In addition to being under-resourced, most of these careworkers are being overworked, underpaid and under-appreciated (Davis, 2020; Malherbe, 2020). Moreover, these workers are, themselves, facing ongoing and acute exposure to the virus, and are thereby experiencing high rates of infection (Fisher et al., 2020).

While there has already been considerable research into the manifold effects of and responses to COVID-19, we still need to better understand its multifarious socio-political outcomes. Certainly, the true extent and medium-to-long-term consequences of the pandemic on communities and societies, particularly in the Global South, requires further examination. Beyond its immediate public health and socioeconomic impacts, we will need to develop in-depth analyses on the pandemic’s heterogeneous effects on income inequality, food insecurity, and the availability of social goods (e.g. quality and safe public transport, education, stable and safe energy supplies, and adequate housing). Moreover, we need to better understand and learn from the different ways by which people have responded to the pandemic, many of which are not immediately discernible and have not been prominent in dominant discourses which have tended to focus on top-down interventions (see Malherbe, 2020; Sitrin & Colectiva Sembrar, 2020). Our world has fundamentally changed, and we need to understand this change if we are to implement socially just transformation. It is this epistemological conjuncture that Social and Health Sciences, along with all of the human sciences, now finds itself.

THE INAUGURAL SPECIAL ISSUE OF SOCIAL AND HEALTH SCIENCES

Social and Health Sciences is the recently refreshed and expanded iteration of African Safety Promotion: A Journal of Injury and Violence Prevention, now in its 19th year of publication. The name change indicates the journal’s renewed scope which allows for consideration of today’s most pressing socio-political concerns, especially the deepening social and economic inequalities, and the evolving intersections of these with the health, safety and peace of those in the Global South. Although located in Africa, Social and Health Sciences invites submissions from authors based in the Global South, as well as the Global North. Social and Health Sciences hopes to embody a multidisciplinary forum for critical discussion and debate among scholars, practitioners, activists, students and policy-makers whose interests and work intersect with the social and health sciences. The journal welcomes theoretical, empirical, applied and policy submissions on such topics as: violence in its multiple forms;
the structural and social determinants of health, safety and peace; injury, health and safety promotion interventions; community engagement; health and safety economics; health and safety systems research; and knowledge production in the social and health sciences. Social and Health Sciences is an accredited South African Post-Secondary Education (SAPSE) journal. All articles in the journal are subject to peer review. The journal will be published biannually and feature original full-length articles, theoretical papers, reviews, and perspectives or commentaries.

In this inaugural Special Issue on the COVID-19 pandemic, particularly its individual, family, community, and societal impacts in Africa and - more broadly - in the Global South, we invited authors to submit reflections on community intervention programmes, the socio-political constitution of the pandemic, as well as the different kinds of health responses which have been observed. We also invited submissions that sought to probe into interventions enacted by government and civil society to manage the pandemic and its consequences. Some suggested topics here included: psychosocial and political implications of the pandemic; effects on material well-being; COVID-19 and identity; pedagogical implications; consequences for political organisation and impacts on policy; public health responses; and social activism in the time of COVID-19.

Due to the overwhelming number of manuscripts that we received, it was decided that we would publish two Special Issues. In this first issue, we have included pieces that outline various social dimensions of the pandemic (e.g. its psychological, social, physical, political, and discursive dimensions). In different ways, each paper seeks to think through our present conjuncture, and points towards future possibilities for research and intervention. Exemplary in this latter respect is the piece by Seneca Louw, Naiema Taliep, Ghouwa Ismail, and Samed Bulbulia, who reflected on how community engagement work has been reconfigured under COVID-19. They interrogate what this means at a structural level, for collaborative partnerships, and the psychosocial challenges therein.

Many of the articles we received were, understandably, psychological in their focus. Elias Oupa Mashile and Matshepo Matoane, for instance, examined the psychological health of emergency service personnel in South Africa’s Free State province. Using exploratory factor analysis, they found that respondents to an online survey experienced intense feelings of vulnerability, exhibited a considerable range in their knowledge of how COVID-19 is spread, and demonstrated low-levels of knowledge on the signs and symptoms of the virus. Similarly, in their study on the mental health impacts of the pandemic in South Africa, Anita Padmanabhanunni and Tyrone B. Pretorius found high levels of hopelessness and depression in participants. These results, they argue, indicate the possibility of a
mental health crisis. It would appear that we neglect the psychological damage that COVID-19 has wrought at our peril. This should form part of our socioeconomic planning in the wake of the virus. In addition to ensuring our physical wellbeing, the mental health of healthcare workers and laypeople must be made a priority.

Many of the articles tackled the sociological dimensions of COVID-19. In offering eight core considerations, Lieketseng Ned, Emma Louise McKinney, Vic McKinney, and Leslie Swartz demonstrate how people with disabilities have been rendered especially vulnerable during the pandemic. They argue that the risk which people with disabilities face during this time has been aggravated through inaccessible healthcare systems. As such, they call for further research into disability-inclusive COVID-19 responses. In other articles, gender proved to be an especially pertinent sociological concern. In relying on a social provisioning framework, Odile Mackett examines how the pandemic has affected South African women. She demonstrates that socio-political issues related to gender inequality have, under the pandemic, been intensified, and emphasises the importance of critical frameworks for understanding such widening inequality. In another article analysing the violent policing of Black men living in townships, Malose Langa and Bandile Bertrand Leopeng examine several media reports which were published during South Africa’s lockdown period. They found that policing was driven by racial and gendered stereotypes, and that the enforcement of lockdown regulations affirmed violent policing masculinities. COVID-19 did not create social inequalities and injustice. Rather, it entered into existing socio-economic and political terrains marked by histories of inequality and violence, and greatly exacerbated these. We therefore cannot effectively fight COVID-19 if we do not, at the same time, address the social ills within which the virus operates.

Finally, although almost all of the pieces submitted to the Special Issue addressed how those in power have responded to the pandemic, for some articles, this was a central focus. Sebastian van As, in his perspective piece, makes comparisons between government responses to the pandemic and road traffic crashes (the latter of which, for van As, represents a pandemic of its own). He notes that little attention has been paid to this latter pandemic, and offers some lessons for road safety campaigners that can be drawn from government responses to COVID-19. In their article, Richard Barber and Siew Fang Law examine how the media reported on the Australian government’s public health policies during the pandemic, policies which they argue were mired in colonial logics and a discourse of whiteness. They also recount the kinds of resistance and community-based solidarity initiatives which responded to these inadequate State policies. In her piece, Thirusha Naidu focuses on issues of naming, and in particular how language has been used in South Africa both to fix the Other within a liminal identity space, and
to blame the Other for the suffering experienced during the country’s lockdown period, thereby allowing structural oppression to remain intact. As a response to this, she recounts how activists have utilised language, oftentimes in artistic forms, to protest oppression as well as what she calls the suffocation of identity. In all of these articles, social critique functioned as an analysis of dominant powers as well as a critical consideration of egalitarian future-building (much of which is, prefiguratively, being observed in the present). While the immediate practicalities of tackling the pandemic cannot be ignored, it is also important that we look imaginatively and ambitiously ahead towards a safer and more equal world.

For most of 2020, the COVID-19 pandemic has dominated the discursive, ideological and material facets of our lives. Indeed, when we are not talking or reading about the pandemic, we are experiencing its effects. And yet, we are still grappling with how to live with its effects, and even how to understand what this means for the present, let alone the future. The articles featured in this Special Issue, along with those which will be published in the following Special Issue, represent some nascent attempts at understanding COVID-19, its immediate consequences, long-term valances, and metaphysical quandaries. It is through such a range of studies, reflections, perspectives, and treatises that we may begin to address the unacceptable social maladies that have long preceded COVID-19, and that will continue to prevent effective treatment of this virus, as well as future viruses. We hope that this Special Issue, along with future issues of Social and Health Sciences, will contribute to understanding a social world in flux so that we can begin contributing to the development of a healthier, more equal, and just world.

REFERENCES


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Original Contributions

The Psychological Reactions of Emergency Medical Services Personnel to COVID-19 in South Africa

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ABSTRACT

The onset of the COVID-19 crisis in South Africa has brought about changes in the lifestyles and livelihoods of many citizens. The drastic steps taken by governments worldwide have escalated concerns amongst the population about effective measures to address it. Emergency services personnel are at the forefront of measures to manage the pandemic. How their conditions of work and exposure to infected citizens affect their psychological health is key in ensuring a responsive health system. In this study, we investigated the psychological health of emergency services personnel in the Free State province of South Africa. 1023 personnel completed an online survey and exploratory factor analysis was employed to extract three factors of concern to the respondents. The first factor indicated that most respondents experienced feelings of vulnerability in respect of contracting COVID-19. The second factor indicated a marginal split in the levels of knowledge held by respondents in respect of behaviours aimed at containing the spread of COVID-19. The third factor indicated low levels of knowledge pertaining to signs and symptoms of the pandemic. The results of a correlation analysis indicated a positive correlation between the professional practices of personnel and their levels of perceived vulnerability. The need for support of health care workers in times of a pandemic were shown to be critical in the fight against the COVID-19.

Keywords: COVID-19; psychological health; vulnerability, emergency medical services.

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INTRODUCTION

On 31 December 2019, China reported an initial case of pneumonia due to an unknown cause and arising in the city of Wuhan. On 11 February 2020, the virus behind the case was named COVID-19 by the World Health Organization (WHO). Within a short space of time, China witnessed an outbreak of the disease and it soon spread across the globe, reaching South Africa in March (WHO, 2020b). Just four months after the start of the outbreak, the WHO had already declared COVID-19 a pandemic. As of 28 July 2020, WHO had recorded 16 301 736 confirmed cases and 650 069 confirmed deaths worldwide due to COVID-19, along with 445 433 confirmed cases and 6 769 deaths in South Africa (WHO, 2020a).

Business was severely affected across all sectors of society, world-wide, as the pandemic disrupted operations in all spheres. This was evidenced by the resultant international travel bans, cancellations of major international and national events, restrictions on all forms of gatherings and the call for employees to work remotely where possible. Such curtailment of normal human movement has the potential to induce fear, anxiety, anger and even depression amongst individuals as they attempt to adjust to what often becomes known as the “new normal”. Studies conducted on how COVID-19 affects the psychological well-being of individuals confirm its manifestation in anxiety, fear, frustration, uncertainty and stress (Cao et al., 2020; Chen et al., 2020; Ho, Chee, & Ho, 2020; Roy et al., 2020). Serafini et al. (2020), in their review of the psychological impact of lockdown restrictions and quarantine, add acute stress disorder, depressive symptoms, post-traumatic stress disorder, avoidance behaviour, nervousness and sadness to the list. In yet another review, Brooks et al. (2020) draws a distinction between stressors that occurred both during and after the quarantine period – these include fear of being infected with the virus or of infecting loved ones (Ho et al., 2020), frustration and boredom. Poor information, insufficient guidelines and a lack of clarity about the different levels of risk were further found to increase the stress levels of individuals (Roy et al., 2020; Serafini et al., 2020). These studies illustrate the negative ramifications of COVID-19 and other health-related threats for individuals’ psychological functioning.

The rapid spread of the pandemic across the globe resulted in government officials experiencing pressure to develop interventions that would curb its spread as well as prepare their health care systems to cope with the resultant increases in the consumption in health services that were anticipated (WHO, 2020a). Concerns [expressed by health care workers at the frontline of managing the pandemic] over
the ability of health systems to cope with the pandemic may negatively impact health care workers’ mental health status. The extent to which health workers feel uncertain about the disease, unpredictability in the response from officials, and misinformation may also contribute to the stress and mental morbidity for health care workers (Zandifar & Badrfam, 2020). It is for this reason that Pappa et al. (2020) advocate for the immediacy of interventions and clarity in communication as ways in which the capacity of health care systems and the psychological resilience of health care workers can be enhanced. According to Greenberg, Brooks, Wessely, and Tracy (2020), in order to positively influence the mental health of employees during times of infectious disease outbreaks, it is important for employers to communicate accurate and up-to-date information.

Research on the impact of COVID-19 on the mental health of health care workers tends to point to their specific vulnerability in this area. For instance, Rajkumar (2020) views health workers as particularly at risk of experiencing mental health challenges during COVID-19 outbreaks. In support, Ho et al. (2020) and Pappa et al. (2020) include high levels of stress, anxiety, depression and trauma as typical symptoms amongst health care workers in the face of COVID-19. A systematic review of empirical research studies (Pappa et al., 2020) highlighted gender and occupational differences in levels of vulnerability amongst health care workers. In their study on immediate and sustained psychological impact of an emerging infectious disease outbreak on health care workers, McAlonan et al. (2007, p.246) conclude that: “stress management for frontline health care workers is integral to a protocol for outbreak preparedness. In a similar vein, Greenberg et al. (2020) argue for supportive management practices (such as conversations with staff on their mental health and monitoring of staff likely to contract infectious diseases) as strategies for fostering better mental health amongst health care workers. These studies on the impact of COVID-19 on the mental health of health care workers influenced our interest in exploring the impact of COVID-19 on the psychological wellbeing of Emergency Medical Services personnel working in the Free State province of South Africa.

As part of the South African government’s attempt at managing the COVID-19 pandemic, the Department of Health in the Free State province initiated a COVID-19 awareness training programme for its Emergency Medical Services (EMS) personnel immediately after the implementation of the lockdown restrictions imposed by the President of the Republic of South Africa. With the first cases of COVID-19 in South Africa having been detected only in March of 2020, there still exists a dearth of literature on the manifestation of the pandemic in the country. This is evidenced by research that was cited earlier and which emanates mainly from China and India (Cao et al., 2020; Ho et al., 2020; Rajkumar, 2020; Wang et al., 2020). With the current researchers investigating the EMS personnel’s
COVID-19 knowledge, attitudes and behaviour, as well as the impact of COVID-19 on their psychological wellbeing, the researchers hope to contribute towards relieving this dearth in the literature. In line with studies conducted elsewhere, which illustrate the negative impact of infectious disease outbreaks such as Ebola, H1N1 influenza, severe acute respiratory syndrome (SARS), and COVID-19 on individuals’ psychological health (Brooks et al., 2020; Ho et al., 2020; Reynolds et al., 2008; Roy et al., 2020), the researchers working on the current study built in a component that sought to assess the psychological reactions of EMS personnel to COVID-19. It is hoped that such an understanding will contribute towards the provision of a holistic approach to the management of COVID-19 in the country.

The psychological statuses of individuals, when caused by emergencies or pandemics, are often associated with those individuals’ levels of knowledge and attitude and may have a large influence on behaviour towards the disease (Roy et al., 2020). EMS personnel are at the frontline of health systems and thus provide an important service in the fight against the pandemic. Hence, the knowledge and psychological status of EMS personnel are key considerations in the management of the pandemic.

METHODS

STUDY SAMPLE

The target population for this study was EMS personnel in the Free State province of South Africa. The Department of Health in the province organised a series of COVID-19 awareness training workshops for all its EMS personnel at the beginning of March 2020. The researchers targeted participants from these workshops as their research respondents. A questionnaire was distributed to participants in the form of a link to allow research participants to complete it online at the site of training. Arrangements were made with the workshop facilitators to allow participants about twenty (20) minutes to fill in the questionnaire prior to conducting the workshops.

RESEARCH INSTRUMENT

We developed a structured questionnaire to assess participants’ levels of COVID-19 knowledge, their attitudes and associated behaviours, as well as the impact of the pandemic on their psychological health. The questionnaire comprised four sections. Section one was aimed at gathering participants’
demographic information (gender, age, highest level of education). In section two, the questionnaire inquired as to participants’ knowledge and understanding of the signs and symptoms of COVID-19 and the attitudes they held towards the pandemic, as well as their knowledge on the kinds of behaviours that are required to contain the spread of COVID-19. Questions for this section were primarily derived from facts about COVID-19 as per the National Institute for Communicable Diseases (NICD, 2020) and the WHO (WHO, 2020c) guidelines. The content and accuracy of the questions were verified by the medical practitioner who was training the EMS personnel. The approach was largely informed by the knowledge, attitudes and behaviour (KAB) model to managing illness and disease (Kilale, 2016; Launiala, 2009). Section three of the questionnaire contained some of the items from section two, with a specific focus on contextualising these to EMS personnel’s professional practice. This was aimed at understanding how their specific context contributed to the spread of the pandemic. The fourth section of the questionnaire was aimed at assessing the impact of COVID-19 on participants’ psychological health. Items from this section were mainly aimed at assessing participants’ perceived vulnerability in respect of contracting COVID-19, along with their resultant reactions. We used a 3-point Likert scale for all items. The final section consisted of an open-ended question inviting participants to share anything related to COVID-19 that may not have been covered in the study. For the purposes of this article, we will focus on the first four sections of the study only.

DATA ANALYSIS

We used the Python SciPy library and SPSS version 26 to analyse the data. Descriptive statistics were used to analyse the characteristics of the respondents. Exploratory factor analysis was carried out on the Likert items to determine the dimensionality of the questionnaire. Item analysis (Cronbach alpha) was performed on the scales to determine the reliability of the identified constructs. We explored significant associations between the demographic variables and psychological health. Significant variables were included in a multivariate logistic regression analysis to determine the impact on the psychological health of EMS personnel. Pearson’s correlation coefficient was used to evaluate the association between constraints on EMS personnel work conditions and psychological health.

ETHICAL CONSIDERATIONS

This study received ethical clearance from the Unisa Research Ethics Committee. Participation was voluntary and information about the study was provided to participants prior to commencing with the
questionnaire. Participants gave informed consent to participate in the study after being notified of the confidential considerations that will be used.

RESULTS

1023 EMS practitioners consented and completed the questionnaire. The sample was made up of 52% males and 45% females. 3% of the sample identified their gender as other. The age distribution was mostly in the thirties (36.8%) and forties (48.1%). The other age groups were the fifties and above (10.5%) and those under 30 (4.6%). The highest level of education was predominantly a post-school certificate or diploma (95.7%). Participants with an undergraduate degree constituted 2.5% and those with a postgraduate qualification constituted 1.8%.

DIMENSIONS OF THE QUESTIONNAIRE

The Kaiser-Meyer-Olkin measure of sampling adequacy (MSA) (0.8) and Bartlett’s test of sphericity (p < 0.001) indicated that the questionnaire could be factorised (Costelo & Osborne, 2005). The characteristics of the dataset necessitated the use of principal axis factoring with oblique rotation (Osborne, 2014). Using information from the scree plot and loadings on the pattern matrix, three factors were extracted (Table 1).

Table 1: Initial Eigenvalues of the extracted factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Initial Eigenvalues</th>
<th>Rotation Sums of Squared Loadings</th>
<th>Total % of Variance</th>
<th>Cumulative %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological status</td>
<td>3.008</td>
<td>18.798</td>
<td>18.798</td>
<td>18.798</td>
<td>2.302</td>
</tr>
<tr>
<td>Knowledge of containing behaviours</td>
<td>1.773</td>
<td>11.078</td>
<td>29.877</td>
<td>0.946</td>
<td>1.127</td>
</tr>
<tr>
<td>Knowledge of signs and symptoms</td>
<td>1.447</td>
<td>9.041</td>
<td>38.917</td>
<td>0.946</td>
<td>0.946</td>
</tr>
</tbody>
</table>

Note: aExtraction Method: Principal Axis Factoring. bWhen factors are correlated, sums of squared loadings cannot be added to obtain a total variance.
PSYCHOLOGICAL STATUS OF PRACTITIONERS (FACTOR 1)

The first factor was made up of six variables measuring perceived vulnerability to contracting COVID-19 and resultant reactions, with an alpha reliability of 0.8. The items loading on this factor are:

- I am afraid of contracting the COVID-19 virus
- I am always pre-occupied with the thought of contracting the COVID-19 virus
- I lay awake at night thinking about my chances of contracting the COVID-19 virus
- I have lost my appetite since I started thinking about the possibility of contracting the COVID-19 virus
- I worry about infecting my loved ones with the COVID-19 virus
- As a result of worrying about the COVID-19 virus, I tend to avoid the company of others and prefer to be by myself

Psychological Reactions of EMS Practitioners towards Contracting COVID-19

Analysis of descriptive statistics shows that the majority of EMS personnel exhibited heightened levels of vulnerability towards contracting COVID-19. 57.58% of personnel felt slightly vulnerable towards contracting the virus while 32.94% perceived themselves as most vulnerable of contracting COVID-19. Only 9.48% of participants did not see themselves as vulnerable to contracting the virus. The results are indicative of a large proportion of EMS personnel who feel vulnerable to contracting COVID-19, possibly due to the nature of their work, which predisposes them to the virus. The large proportion of individuals concerned about contracting the virus has implications for the provincial health system, demonstrating support for the provision of mental health services for practitioners during the pandemic (Roy et al., 2020).

Factors Affecting the Vulnerability Levels of EMS Personnel

The results of univariate analysis depicting the relationship between demographic variables and levels of personnel vulnerability are shown in Table 2. Gender and age had no significant influence on the levels of vulnerability of EMS personnel. Participants’ level of education had a significant effect on their levels of vulnerability (p < 0.05). In particular, personnel with a post-school certificate or diploma (32.06%) exhibited greater levels of perceived vulnerability towards contracting COVID-19. This may imply that exposure to some form of post-schooling education raises the level of awareness to the reality
and possible risk that such personnel are subjected to in their line of work, hence the high levels of perceived vulnerability.

Table 2: Univariate analysis of EMS personnel's mental health characteristics

<table>
<thead>
<tr>
<th>Vulnerability levels</th>
<th>Gender (%)</th>
<th>Age (%)</th>
<th>Education (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>&lt;30</td>
</tr>
<tr>
<td>None</td>
<td>52 (5.08)</td>
<td>45 (4.4)</td>
<td>6 (0.59)</td>
</tr>
<tr>
<td>Slightly high</td>
<td>310 (30.3)</td>
<td>279 (27.37)</td>
<td>31 (3.03)</td>
</tr>
<tr>
<td>Severely high</td>
<td>170 (16.62)</td>
<td>167 (16.32)</td>
<td>9 (0.88)</td>
</tr>
<tr>
<td>Statistics</td>
<td>127567.5</td>
<td>3.210234b</td>
<td>8.752750b</td>
</tr>
<tr>
<td>P</td>
<td>0.2585</td>
<td>0.3603</td>
<td>0.0126</td>
</tr>
</tbody>
</table>

Knowledge of containing behaviours

<table>
<thead>
<tr>
<th></th>
<th>low</th>
<th>medium</th>
<th>high</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18 (1.76)</td>
<td>249 (24.34)</td>
<td>265 (25.9)</td>
</tr>
<tr>
<td></td>
<td>17 (1.66)</td>
<td>218 (21.31)</td>
<td>256 (25.02)</td>
</tr>
<tr>
<td></td>
<td>1 (0.1)</td>
<td>20 (1.96)</td>
<td>25 (2.44)</td>
</tr>
<tr>
<td></td>
<td>10 (0.98)</td>
<td>169 (16.52)</td>
<td>198 (19.35)</td>
</tr>
<tr>
<td></td>
<td>21 (2.05)</td>
<td>229 (22.39)</td>
<td>243 (23.75)</td>
</tr>
<tr>
<td></td>
<td>3 (0.29)</td>
<td>49 (4.79)</td>
<td>55 (5.38)</td>
</tr>
<tr>
<td></td>
<td>493 (48.19)</td>
<td>451 (44.09)</td>
<td>35 (3.42)</td>
</tr>
<tr>
<td></td>
<td>16 (1.56)</td>
<td>10 (0.98)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>12 (1.17)</td>
<td>6 (0.59)</td>
<td>0</td>
</tr>
<tr>
<td>Statistics</td>
<td>128215.0a</td>
<td>1.4777b</td>
<td>7.2175b</td>
</tr>
<tr>
<td>P</td>
<td>0.3031</td>
<td>0.6874</td>
<td>0.0271</td>
</tr>
</tbody>
</table>

Knowledge of signs & symptoms

<table>
<thead>
<tr>
<th></th>
<th>low</th>
<th>medium</th>
<th>high</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>41</td>
<td>286</td>
<td>205</td>
</tr>
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<td></td>
<td>57</td>
<td>233</td>
<td>201</td>
</tr>
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<td>8</td>
<td>27</td>
<td>11</td>
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<tr>
<td></td>
<td>34</td>
<td>210</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>47</td>
<td>239</td>
<td>207</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>43</td>
<td>55</td>
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<tr>
<td></td>
<td>394</td>
<td>495</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Statistics</td>
<td>127315.0a</td>
<td>13.8107b</td>
<td>8.2761b</td>
</tr>
<tr>
<td>P</td>
<td>0.2357</td>
<td>0.0032</td>
<td>0.01595</td>
</tr>
</tbody>
</table>

KNOWLEDGE OF BEHAVIOURS CONTAINING SPREAD OF CORONAVIRUS
(FACTOR 2)

Factor 2 had six items that measured the behavioural practices curbing the spread of COVID-19. The reliability of this scale was 0.5. Items loading on this factor were:

- It is safe for me to touch someone who is infected with the COVID-19 virus, as long as they have covered their nose and mouth.
- If someone has a fever and a runny nose, it is safe for me to touch them, as long as they are not coughing or feeling tired.
- It is not necessary for me to wash my hands with soap after touching my patients, as long as the patients did not display serious symptoms of the COVID-19 virus.
- It is sufficient for me to wash my hands with soap and water or an alcohol-based hand rub three times a day.
- It is safe for me to cover my mouth and nose with my bare hands when I cough or sneeze, as long as I keep a distance of 1 meter from those around me.
- If someone contracts the COVID-19 virus, they deserve to be isolated because they called the virus upon themselves.

From the study’s analysis, 50.9% of the EMS personnel possess high levels of knowledge about behaviours that contain the spread of the pandemic while 45.65% possess moderate knowledge about behaviours that contain the spread of the pandemic. Only 3.42% of the personnel possess very low levels of knowledge about behaviour that contain the spread of the pandemic. These results indicate that this group of EMS personnel seem unsure of the types of behaviours that are required to curb the spread of the pandemic.

*Factors Affecting Personnel’s Knowledge of Behaviours Containing the Spread of COVID-19*

Table 2 shows the relationship between EMS personnel’s knowledge of behaviours containing the spread of COVID-19 and demographic variables. No significant interaction effects were found for gender and age. Educational background however had significant effects on personnel’s knowledge of behaviours containing the spread of the coronavirus. This implies that those with post-schooling education tend to be more informed about the types of behaviours that are necessary to contain the spread of the pandemic.
KNOWLEDGE OF THE SIGNS AND SYMPTOMS OF COVID-19

The third factor is made up of items measuring individuals’ knowledge of the signs and symptoms of COVID-19. Three items loaded on the third factor with an alpha reliability of 0.4:

- If I treat a patient who suffers from a heart condition, they are more likely to die from COVID-19 complications
- If I have a fever and dry cough, but do not experience difficulty breathing, I am likely to be suffering from COVID-19
- If I assist a patient who suffers from acute respiratory infections, I run the risk of being infected with the COVID-19 virus

The analysis of the findings of this study indicate that only 39.69% of the EMS personnel possess high levels of knowledge on the signs and symptoms of COVID-19. A large proportion of the personnel, 50.73%, possess a moderate amount of knowledge on the signs and symptoms of COVID-19, while only 9.58% possess very low levels of knowledge on the signs and symptoms of COVID-19. This shows a relatively less informed group of EMS personnel on how COVID-19 is manifested.

Factors Affecting Personnel’s Knowledge of COVID-19 Related Signs and Symptoms

EMS personnel’s knowledge of signs and symptoms of the pandemic is shown in Table 2. There was a significant relationship between this knowledge and age ($p < 0.05$). Similarly, there was a significant relationship between personnel’s knowledge of coronavirus signs/symptoms and levels of education ($p < 0.05$). No significant relationships were found for gender. These relationships may mean that the more exposure to post-schooling that one has, the more they are likely to detect the signs and symptoms of COVID-19. The relationship between knowledge of the signs and symptoms of COVID-19 is rather difficult to understand as there does not seem to be a clear pattern in relation to age. It might have been reasonable to expect knowledge of the signs and symptoms of COVID-19 to be either greater/lesser in respect of an older/younger respondent. However, in the current findings, there is no such pattern in the profile of the results.

ORDINAL REGRESSION ANALYSIS

The results of the factor analysis pointed to the possible association of factors 2 and 3 with EMS personnel’s vulnerability due to COVID-19. We therefore included the two factors, together with the
significant factors from the univariate analysis, in an ordinal regression analysis (Table 3). Education was a significant predictor of vulnerability (Wald $\chi^2(1) = 6.918$, $p = 0.009$). The log odds of being least vulnerable were 0.552 for personnel with higher educational backgrounds, compared with those with lower education. The odds of personnel with higher education being least vulnerable due to COVID-19 were 1.737 (95% CI, 1.151 to 2.620) times those of personnel with lower educational backgrounds. Similarly, the odds of personnel with higher knowledge of behaviours containing the spread of COVID-19 being least vulnerable were 1.51 (95% CI, 1.216 to 1.876) times those of personnel with lower knowledge, a statistically significant effect (Wald $\chi^2(1) = 13.922$, $p = 0.000$). Surprisingly, the results show that the odds of personnel with low knowledge of signs and symptoms of COVID-19 being least vulnerable are 0.727 (95% CI, 0.597 to 0.885) times less than the odds of those with higher knowledge of signs and symptoms of COVID-19, a statistically significant effect (Wald $\chi^2(1) = 10.142$, $p = 0.001$).

**Table 3: Ordinal logistic regression of factors influencing the vulnerability of EMS personnel**

<table>
<thead>
<tr>
<th>Factors</th>
<th>B</th>
<th>OR</th>
<th>P</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>0.552</td>
<td>1.737</td>
<td>0.009</td>
<td>1.151-2.620</td>
</tr>
<tr>
<td>Factor 2</td>
<td>0.412</td>
<td>1.51</td>
<td>0.000</td>
<td>1.216-1.876</td>
</tr>
<tr>
<td>Factor 3</td>
<td>-0.319</td>
<td>0.727</td>
<td>0.001</td>
<td>0.597-0.885</td>
</tr>
</tbody>
</table>

Note: B (parameter estimate), OR (odds ratios), CI (confidence interval)

**EFFECTS OF EMS’ PROFESSIONAL PRACTICE ON COVID-19**

We hypothesised that, irrespective of the level of personnel’s knowledge of COVID-19, the context within which they conduct their work can either inhibit or promote their ability to practise behaviours that contain the spread of the pandemic. Furthermore, we would like to know the extent to which the impact of these contexts affects the EMS personnel’s level of vulnerability to contracting COVID-19. Table 4 shows the correlation between this level of vulnerability and three behavioural variables which are impacted by professional practice. Inability to maintain social distance due to work constraints was positively correlated with the EMS personnel’s level of vulnerability ($r = 0.107$, $p < 0.001$). In other words, EMS personnel who found their work context to be inhibiting their ability to practice social distancing perceived themselves to be most vulnerable to contracting the virus. Similarly, touching one’s face while busy with work was positively correlated with personnel’s levels of vulnerability ($r = 0.148$, $p < 0.001$). This means that those EMS personnel who were not able to refrain from touching
their faces perceived themselves as most vulnerable to contracting COVID-19. The relationship between washing hands regularly and vulnerability to contracting COVID-19 was, however, not statistically significant.

Table 4: Work constraints impacting on behaviours containing spread of coronavirus

<table>
<thead>
<tr>
<th>Work constraints</th>
<th>Vulnerability to contracting COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pearson r</td>
</tr>
<tr>
<td>Not possible to maintain social distance</td>
<td>0.107</td>
</tr>
<tr>
<td>Able to wash hands repeatedly</td>
<td>0.001</td>
</tr>
<tr>
<td>Impossible not to touch face</td>
<td>0.148</td>
</tr>
</tbody>
</table>

DISCUSSION

Most of the EMS personnel in this study expressed perceived feelings of vulnerability towards contracting COVID-19. While a review of existing mental health literature on COVID-19 confirms the significant risk of health care workers towards mental health outcomes during COVID-19, the reasons mentioned for these include long working hours, risk of infection, shortages of protective equipment, loneliness, physical fatigue and separation from families (Rajkumar, 2020). Our study reflects an additional contributor to the risk. It is possible that the nature of participants’ work, which often entails having to perform mouth-to-mouth resuscitation, checking the heartbeat of their patients as well as checking for the dilation of their patients’ pupils, to name just a few of their key performance areas, is a key driver of these perceived feelings. Their responses as to whether they are able to maintain social distancing in their line of duty confirms this. This particular response has also been found to have a significant correlation with these perceived feelings of vulnerability. It is therefore not surprising that they tend to be preoccupied with thoughts of contracting COVID-19 as well as subject to lying awake at night thinking about their chances of contracting the virus. Closely related to these are their expressed feelings of fear and worry, not only about the possibility of themselves being infected by the virus, but the possibility of also infecting their loved ones. Their resultant behavioural reactions include isolating themselves and withdrawing from interacting with others, lack of proper sleep and loss of appetite. These are reactions typically associated with anxiety and depressive symptoms.

It is also possible that these findings are linked to the timing of our research. This research was conducted at the time when the first cases of COVID-19 had just been diagnosed in South Africa and
at the same time there were media reports on the high spikes in infection rates and deaths across the world (as a result of COVID-19), particularly in Italy, China and the UK. Such an environment can heighten feelings of fear and anxiety, most especially amongst EMS personnel who are at the frontline of health care service provision. This appears to approximate what Rajkumar, (2020) (in his review of existing COVID-19 mental health literature) refers to as excessive health anxiety, brought about by exaggerated and inaccurate media reports during an infectious disease outbreak. According to Ho et al. (2020), fear is associated with the outbreak of an infectious disease, especially when there is still much speculation about its mode of transmission and treatment. In South Africa, confounding issues pertain to concerns about personal protective equipment (Dhai, Veller, Ballot, & Mokhachane, 2020; McQuoid-Mason, 2020), equitable access to services (Labuschagne, 2020) and how these could impact on the psychological wellbeing of health care workers.

This particular finding has implications for the mental health of not only EMS personnel, but health care workers in general who find themselves exposed to the risk of contracting the virus. This signals the importance of instituting support programmes for health care workers who are at the forefront of managing the fight against infectious diseases in general, as they present a real threat of infection. Given the findings of this study on the significant relationship between EMS personnel’s levels of education and their perceived levels of vulnerability, any such support programmes should focus particularly on those health care workers whose levels of education are at a lower level in order to educate them about the pandemic and particularly the preventative measures.

A study that reviewed literature on psychological resilience and post-traumatic growth in disaster-exposed organisations revealed that health care workers who were adequately trained/prepared to deal with a disaster/disease outbreak, those with prior experience in working with a particular disaster/disease outbreak, and those with adequate social support and effective coping strategies were less likely to report lasting mental health issues or even report mental health problems (Brooks, Amlôt, Rubin, & Greenberg, 2020). Within the context of the current study, it is thus not surprising that the findings reveal high levels of stress and anxiety amongst EMS personnel, as this appears to be their first exposure to a COVID-19 working environment.

The levels of EMS personnel’s knowledge of the signs and symptoms of COVID-19 were found to be very low, with only 39.69% having high levels of knowledge of the pandemic. This raises concerns with the safety of personnel and their patients. If EMS personnel are not aware of COVID-19 symptoms,
the chances of infecting their patients, or being infected by their patients, are much higher. As COVID-19 is new, even for EMS personnel, care should be taken that myths or lack of proper knowledge do not compromise the prevention and management of the disease. Incorrect knowledge may translate to wrong behaviour or attitudinal dispositions that may increase the spread of the disease. In a country where literacy levels are not high, role models such as EMS personnel may serve as validators of correct information and so their knowledge and disposition are critical in the fight against the coronavirus.

From the analysis of the correlation between EMS personnel’s knowledge of the signs and symptoms of COVID-19 and their demographic characteristics, the more educated the EMS personnel, the more knowledge of the signs and symptoms of COVID-19 they will possess. The analysis also found a significant relationship between age and knowledge about COVID-19 signs and symptoms. One would assume that the older a person becomes, the more aware and exposed to situations in general they will be and the more likely they will be to be informed about illnesses, including COVID-19. However, such an assumption would be too optimistic as experience tends to be a more reliable determinant than mere awareness because the latter depends on personal curiosity and interest. It is thus difficult to understand what this correlation means.

The level of knowledge about behaviours that contain the spread of COVID-19 was also not very convincing. There was a near equal split amongst the EMS personnel on this, with 50.9% possessing high levels of such knowledge and 45.65% possessing moderate levels of such knowledge. Safety considerations for both EMS personnel and their patients is emerging as a theme that needs to be incorporated in the design of interventions that are aimed at supporting health care workers who are at the frontline of the fight against COVID-19. Again, the level of education that EMS personnel have influences their knowledge of behaviours that contain the spread of COVID-19. As a priority, COVID-19 intervention programmes should be targeted at those health care workers with lower educational qualifications. The ability of communities to effectively apply containment measures such as self-isolation and social distancing may cause panic in health sectors that are not well-resourced and may negatively affect psychological well-being (Brooks et al., 2020).

Lastly, the EMS personnel that participated in this study find themselves in a position where they are not able to practice social distancing, including being unable to refrain from touching their faces, behaviours that place them at increased vulnerability to contracting the virus. While the nature of their work may not promote health protective behaviours, it becomes incumbent upon the health authorities
to ensure adequate protective equipment is provided to health care workers so as to reduce their levels of anxiety regarding the pandemic. Studies have shown that social support provided to health care workers provides effective protective mechanisms and alleviates psychological vulnerability (Brooks, Dunn, Amlôt, Greenberg, & James Rubin, 2016; Opie, Brooks, Greenberg, & Rubin, 2020). Ensuring the safety of staff by providing them with adequate personal protective equipment is one way in which management can demonstrate their social support towards their employees, an act that is critical in responding to disaster situations in order to lessen staff’s feelings of vulnerability (Brooks et al., 2015).

LIMITATIONS OF THE STUDY

In this study our aim was to assess the levels of knowledge of EMS personnel who were attending a COVID-19 education training programme. As part of that process, we developed a section in the questionnaire that assessed their psychological responses to the virus. The fact that we did not use a standardized scale to assess participants’ anxiety and depression levels, and instead relied on a broad understanding of psychological theory to tap into their psychological reactions, represents a limitation of this study. We therefore regard this as a pilot study and we thus recommend that future studies expand on this study by adopting a more standardised scale to assess the psychological wellbeing of health care workers.

Having designed our own instrument, it would have been ideal to first pilot it with a few groups of people before rolling it out to a larger sample. However, due to time limitations related to the commencement of this study and the need to catch up with the nature and dynamics of the pandemic, we could not pilot the research instrument, and this poses another limitation to our current study. As we designed the research instrument for this study, we had the opportunity to conduct factor and item analyses of the items used in the instrument to determine their levels of correlation.

CONCLUSION

This study has focussed on the psychological reactions of EMS personnel to COVID-19. Overall, the EMS personnel perceived themselves as vulnerable to contracting COVID-19 and this seems to be influenced by their low levels of knowledge of the signs and symptoms of COVID-19 and of the behaviours required to contain its spread. In addition, their education level and work conditions contribute to their perceived levels of vulnerability. Our findings have implications for interventions.
aimed at managing the spread of the COVID-19 virus.

Firstly, it is our view that intervention programmes that are aimed at containing the spread of COVID-19, or any other infectious disease of this nature, should incorporate a mental health element. While the first line of defence is to educate people on the disease, those at the frontline, such as health care workers, are constantly exposed to the virus and cannot help it and they do experience feelings of vulnerability towards contracting the virus. Thus, education programmes should incorporate a section that deals with defining stress and its signs and symptoms, as well as with how it can be managed. In addition, consideration should be given to providing a telephone or email hotline where personnel can have easy access to a counsellor to discuss their psychological issues (Rajkumar, 2020). Appropriate training has been shown to be necessary in enhancing the skills, knowledge and confidence of health care workers during emergencies (Brooks et al., 2015), with the potential to positively affect their psychological wellbeing.

Secondly, given that the kind of health protective behaviours that are required to combat the spread of the coronavirus mirror basic hygiene behaviours, we would like to propose that for those health workers, whose level of education is lower than matric (or grade 12), further education in these basic hygiene behaviours should be integrated into their induction programme at the point of employment. For those already employed, this should be offered as part of their continuous professional development.

Lastly, personal protective equipment (PPE) in the case of COVID-19, most especially amongst EMS personnel, will serve the purpose of mitigating against feelings of anxiety and fear, thus allowing health care workers to focus their undivided attention towards caring for their patients. Stress has been found to impair cognitive functioning and task performance (McAlonan et al., 2007). In addition, Wang et al. (2020), in their study on the psychological responses of the general population during the initial phases of COVID-19 in China, found that wearing masks was associated with lower levels of anxiety and depression. Furthermore, perceived and actual social support provided to health care workers provides an effective protective mechanism and alleviates psychological vulnerability (Brooks et al., 2016; Opie et al., 2020). Ensuring the safety of staff and providing them with adequate personal protective equipment is critical as a response to disasters, otherwise staff experience vulnerability (Brooks et al., 2015).
REFERENCES


When Coping Resources Fail: The Health-Sustaining and Moderating Role of Fortitude in the Relationship Between COVID-19-Related Worries and Psychological Distress

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ABSTRACT

The COVID-19 pandemic is a global public health crisis and governments worldwide have attempted to mitigate the spread of the virus by implementing a range of stringent preventative measures. However, both the pandemic and the preventative strategies enacted may undercut critical protective factors that are known to buffer the negative impact of psychological stressors. The current study aimed to characterise the mental health impact of the pandemic in South Africa by investigating the potential protective role of fortitude in the relationship between COVID-19-related worries and psychological distress, indicated by the levels of depression and hopelessness. The participants were 337 young adults who completed four self-report questionnaires: the Fortitude Questionnaire, the Beck Hopelessness Scale, the Centre for Epidemiological Depression Scale and the COVID19-Related Worries Scale. In addition to descriptive statistics, path analysis was performed to determine the direct, indirect, mediating and moderating effects of fortitude on psychological distress. In this regard, psychological distress was conceptualised as a latent variable that is defined by the two indices of depression and hopelessness. The results demonstrated unprecedented levels of hopelessness and depression among the study sample. These levels were significantly higher than those encountered in previous studies in other contexts, suggesting a possible mental health crisis in the country. Women reported higher levels of psychological distress than men. On its own, fortitude had significant direct effects on psychological distress, affirming its role as a protective factor. However, fortitude was found to have an aggravating rather than buffering effect in interaction with worries. In this regard, the relationship between COVID-19-related worries and psychological distress was stronger among those with high levels of fortitude.

Keywords: COVID-19, depression, fortitude, hopelessness, moderator, worries, South Africa
INTRODUCTION

The 2019 coronavirus disease (COVID-19) outbreak is a major global public health crisis that resulted in the implementation of stringent pandemic-related prevention measures to curtail the spread of the virus. In South Africa, these measures included a prolonged period of national lockdown, prohibitions on in-person contact, quarantine, mandatory social distancing and stay-at-home directives. Prevention measures also included the closure of all non-essential business sectors such as hospitality, retail and tourism (South African Government Gazette, 2020). From March to July 2020, the South African public experienced a confluence of economic stressors, social isolation, job insecurities, separation from loved ones and health-related anxieties. International research has drawn a connection between these factors and an increased incidence of mental health disorders among the general population (Palgi et al., 2020; Tso & Park, 2020; Zhang et al., 2020). The increase in mental health disorders has been suggested to be particularly prevalent in countries with high rates of COVID-19 infection and those in which psychological interventions have not been formally incorporated into protocols for managing disease outbreaks (Rajkumar, 2020).

Emerging international evidence suggests that the salient mental health consequences of the pandemic include heightened COVID-19-related worries and elevated levels of anxiety, depression and hopelessness (Tso & Park, 2020; Zhang et al., 2020). Several studies have documented an increase in COVID-19-related worries among individuals who are at heightened risk of infection due to personal factors such as underlying health issues and socio-economic circumstances, among whom are those who work in high-risk environments or live in overcrowded areas with limited access to personal protective equipment (Barzilay et al., 2020; Joensen et al., 2020; Serafini et al., 2020). COVID-19-related worries are predominantly related to becoming infected, infecting others and compromising the health of family members (Barzilay et al., 2020). Fear of contracting and spreading the virus and constant vigilance regarding potential health-related threats have been found to lead to heightened anxiety and a sense of hopelessness (Dymecka et al., 2020). In addition, pandemic-related prevention measures, such as prolonged social isolation, have been connected to pervasive loneliness and depression, possibly due to the impact of these prevention measures on individuals’ access to social support networks (Serafini et al., 2020). Uncertainty about the progression of the epidemic has been linked to increased worries about the possibility of infection, hopelessness about the future and reduced life satisfaction (Huang & Zhao, 2020). In sum, it is probable that each stressor (job insecurity, health-
related worries, etc.) or a combination of stressors can lead to psychological distress in the form of anxiety, depression and hopelessness.

Pandemics are generally associated with increased susceptibility to the adverse mental health outcomes described above; however, there is also evidence of differential vulnerability to psychological distress (Barzilay et al., 2020). Some people develop significant mental health problems in response to a pandemic, whereas others are able to effectively adapt to crises; this phenomenon suggests the influence of specific protective factors. Examples of protective factors include locus of control (Carter et al., 2014; Goldzweig, Hasson-Ohayon, Alon, & Shalit, 2016); self-esteem (Kong, Zhao, & You, 2013); the use of adaptive coping strategies (Prentice et al., 2020); a sense of coherence (Gómez-Salgado et al., 2020) and willingness to access supportive family networks (Brown, Doom, Lechuga-Peña, Watamura, & Koppels, 2020). These protective factors are often described as having a moderating function in that they buffer the potentially adverse effects of negative environmental conditions (Pretorius, 2020). However, there are three additional pathways by which protective factors can influence the relationship between adverse conditions and psychological functioning: direct, mediating and indirect (Shumaker & Brownell, 1984).

The direct effect hypothesis is also referred to as the health-sustaining model; and this model proposes that the effect of a protective factor (social support) on psychological well-being is independent of the level of the negative environmental conditions (Shumaker & Brownell, 1984). Therefore, an increase in the level of the protective factor would presumably result in increased wellbeing, irrespective of the level of the adverse condition. Moderator variables are presumed to have a stress-reducing or buffering function because they reduce the impact of stress on physical and psychological functioning (Shumaker & Brownell, 1984). In contrast, mediating variables are considered to be the mechanism through which the adverse environmental condition influences the psychological outcome (Pretorius, 2020). Indirect effects imply that protective factors may not be directly related to psychological functioning but may influence appraisals of the stressor and therefore influence wellbeing (Pretorius, 2020).

In the South African context, fortitude has been extensively investigated as a potential protective factor in psychological outcomes in the context of adversity (De Villiers & Van den Bergh, 2012; Padmanabhanunni, 2020; Pretorius, Padmanabhanunni, & Campbell, 2016). Fortitude is defined as the psychological strength to manage stress and remain well; and it is derived from positive cognitive appraisals of self, family and social networks (Pretorius et al., 2016).
Several studies (Hameed, Khan, Shahab, Hameed, & Qadeer, 2016; Padmanabhanunni, 2020) have confirmed that people who have higher levels of fortitude are able to effectively adapt to life stressors and maintain levels of life satisfaction and psychological wellbeing, despite adversity. Fortitude has also been found to have moderating effects in the relationship between exposure to violence and traumatic stress symptoms (Pretorius et al., 2016), locus of control and motivation (Hameed et al., 2016) and stress and anxiety-depression symptoms (Vermaas, 2010). Based on these findings, fortitude may represent an important dimension in coping and adapting in the context of the current pandemic; and it, therefore, warrants further investigation. The current study aimed to characterise the mental health impact of the pandemic in South Africa by investigating the potential protective role of fortitude in the relationship between COVID-19-related worries and psychological distress indicated by levels of depression and hopelessness.

METHODS

PARTICIPANTS

This study used a cross-sectional research design. The participants (N = 337) were a random sample of undergraduate students enrolled at the University of the Western Cape (UWC) in the Western Cape Province of South Africa. UWC is regarded as a historically disadvantaged institution (HDI or historically black institutions). During the apartheid era, HDIs were established by the government for black South Africans and were significantly under-resourced and mainly located in former homelands. Although there has been significant transformation in the education sector since the end of apartheid, the student population at HDIs is largely from working class backgrounds (Habib, 2016; Mdepa & Tshiwula, 2012). UWC predominantly attracts students from historically marginalised groups; and this is reflected in the racial profile of undergraduate students at the university: black African (48%), coloured (45%), white (3.8%), and Indian (2.8%). In the present study, the majority of participants were female (77.2%) and the mean age of the participants was 22 years (SD = 4.7). With reference to COVID-19 status, 82.5% indicated that they had not contracted the virus. A smaller proportion of students either suspected that they had COVID-19 (3.9%) but had not tested for the disease; or suspected that they had the virus and confirmed this through testing (1.2%).
INSTRUMENTS

The participants completed four self-report measures in the period March 2020 to June 2020: The Fortitude Questionnaire (FORQ; Pretorius, 1998), the Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974), the Centre for Epidemiological Depression Scale (CESD; Radloff, 1977) and the COVID 19-Related Worries Scale (COVID 19 RWS), which is a subscale of the World Health Organization (WHO) COVID 19 Behavioural Insights Tool (WHO, 2020). In addition, the participants completed a demographic questionnaire that contained items pertaining to age, gender and area of residence.

The FORQ is a 20-item questionnaire that consists of participant appraisals in three domains: self-appraisals, family appraisals and support appraisals. Fortitude is based on the interaction between these three domains. The FORQ uses a four-point scale that ranges from Does not apply to Applies very strongly. Examples of questionnaire items include I trust my ability to solve new and difficult problems, I have a deep sharing relationship with a number of members of my family and My friends give me the moral support I need. Pretorius (1998) reported a coefficient alpha value of .85 for the scale. Other South African studies have reported reliability coefficients ranging from .77–.88 (Pretorius & Padmanabhanunni, 2020).

The BHS is a widely used measure of hopelessness. It contains 20 statements for which individuals must select “True” or “False” and it assesses the degree to which individuals’ cognitive schemata are associated with pessimistic expectations (I do not expect to get what I really want or My future seems dark to me). Possible scores range from 0–20 with a higher score indicating a greater degree of hopelessness. Internal consistency of .93 has been reported for the BHS, with a concurrent validity of .74 with clinical ratings of hopelessness and .60 with other scales of hopelessness (Beck et al., 1974). The BHS had previously been used in South Africa with a similar sample of young adults (Heppner, Pretorius, Wei, Lee, & Wang, 2002) and an alpha coefficient of .82 was reported in that study.

The CESD scale consists of 20 symptoms, 16 of which have descriptions that are worded negatively and four of which have descriptions that are worded positively. Respondents are asked to indicate how often they experienced each of the symptoms during the past week on a four-point scale, ranging from rarely or none of the time (0) to most or all of the time (4). The items on the scale are assumed to
represent all the major components of depressive symptomatology: (1) depressed mood, (2) feelings of guilt and worthlessness, (3) feelings of helplessness and hopelessness, (4) loss of appetite, (5) sleep disturbance and (6) psychomotor retardation (Radloff, 1977). The CESD scale has demonstrated high internal consistency (.85–.90) and test-retest reliability (.51–.67). Validity has been established through patterns of correlations with clinical ratings of depression. Research has consistently identified a four-factor structure for the CESD scale: positive affect, depressed affect, somatic activity and interpersonal relations (Ferro & Speechley, 2013). The psychometric properties of the CESD scale had previously been reported in use with a sample of South African students (Pretorius, 1991).

The COVID 19 RWS is a 14-item measure of fears and worries related to COVID-19, including personal fears (loss of a loved one) and fears related to broader societal institutions (health system collapsing) and other issues (economic recession). The respondents indicated the extent to which they worry about each of the 14 issues on a five-point scale, ranging from Don’t worry at all (1) to Worry a great deal (5). The scale appears to have been developed specifically for COVID-19 research and no reliability or validity data is currently available. In the current study, the COVID 19 RWS demonstrated satisfactory reliability (see results). A preliminary exploratory factor analysis identified four possible factors: worries related to health, loss of liberties, personal finance and the economy. The total scale was used in the current study.

PROCEDURE

Google Forms was used to construct an electronic survey comprising the four instruments. The survey was distributed during the period of national lockdown from March to June 2020. Random sampling was carried out, using an Excel spreadsheet where all undergraduate student numbers were loaded and then a formula was used to select a random sample of students. These students were then contacted via email with an invitation to participate in the study and a link to the survey. Reminders were sent to participants twice per month for a four-month period.

DATA ANALYSIS

SPSS (version 26) was used to determine descriptive statistics, intercorrelations between study variables and reliabilities. Both Cronbach’s alpha and McDonald’s omega are reported for reliabilities due to concerns about coefficient alpha underestimating true reliability in multi-item measurement scales.
(Hayes & Coutts, 2020; Deng & Chang, 2017). The OMEGA macro, written by Hayes and Coutts (2020) for SPSS was used for this purpose.

Structural equation modelling with Amos (version 26) was used to determine the direct, indirect and moderating effects of COVID-19-related worries and fortitude on depression and hopelessness. Amos also provide bootstrapping of confidence levels, and p-values. The direct effects of fortitude on depression and hopelessness serve as a test of its health-sustaining role. In contemporary analysis, indirect effects of the predictor (worries) are regarded as a measure of mediation and the value of the indirect effects indicates the amount of mediation. When fortitude is used as predictor and worries as mediator, the indirect effects of fortitude on psychological distress serve as a measure of the extent to which fortitude affects the interpretation of the stressor (worries). In addition, confidence intervals are used to determine whether the direct and indirect effects are different from zero. If zero does not fall within the confidence interval, the direct and indirect effects are considered significant (Kenny, 2018).

The moderating effects of fortitude were examined by testing the direct effects of the product of the predictor and the presumed moderator (worries x fortitude). The deviation scores (score minus mean) of the predictor and the presumed moderator were used to calculate the product term to avoid the problem of multicollinearity and to assist with the interpretation of interaction effects (Cohen, Cohen, West, & Aiken, 2003).

ETHICS

Ethical approval for the study was obtained from the Humanities and Social Sciences Research Committee of the University of the Western Cape (UWC). The survey was completed anonymously and the participants provided informed consent prior to accessing the survey. Given the context of COVID-19 and the sensitive nature of the questionnaires, the participants were provided with the contact details for the South African Anxiety and Depression Group and the Centre for Student Support Services in case they experienced psychological distress as a result of completing the questionnaire.

RESULTS

The descriptive statistics, intercorrelations and reliabilities are reported in Table 1.
Table 1: Intercorrelations, descriptive statistics and reliabilities of variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Worries</td>
<td>–</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hopelessness</td>
<td>-.01</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Depression</td>
<td>-.22***</td>
<td>.56***</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>4. Fortitude</td>
<td>.11*</td>
<td>-.56***</td>
<td>-.54***</td>
<td>–</td>
</tr>
</tbody>
</table>

Mean: 52.3, 4.7, 27.5, 53.8
SD: 10.7, 4.4, 13.4, 11.5
α: .86, .88, .92, .91
ω: .86, .88, .92, .91

*** p < .001, * p < .05

The mean scores reported for depression and hopelessness (Depression: $M = 27.5$, $SD = 13.4$; Hopelessness: $M = 4.7$, $SD = 4.4$) were substantially higher than the mean scores reported for these scales in other contexts (Hopelessness: Durham, 1982: $M = 2.32$, $SD = 2.25$; Lotfi-Kashani, Fallahi, Akbari, Mansour-Moshtaghi, & Abdollahi, 2018: range = 1.70 to 4.45; Depression: Crawford, Cayley, Lovibond, Wilson, & Hartley, 2011: $M = 14.08$, $SD = 10.91$; Giuntella, Hyde, Saccardo, & Sadoff, 2020: $M = 14.59$, $SD = 9.64$). There were significant differences between men ($M = 23.3$, $SD = 12.9$) and women ($M = 28.5$, $SD = 13.2$); women reported higher levels of depression ($t_{332} = -2.99$, $p = .003$). In terms of the traditional CESD cut-off score of ≥ 16 for clinical depression (Cameron et al., 2020), 79.2% of the sample obtained a depression score of 16 or higher.

Each of the scales demonstrated satisfactory reliability in terms of the alpha and omega coefficients, which were identical (α and ω = .86—.92). Fortitude was negatively related to depression ($r_{335} = -.56$, $p < .001$) and hopelessness ($r_{335} = -.54$, $p < .001$) and the indices of psychological distress were positively related to each other ($r_{335} = .56$, $p < .001$).

The statistical model that was used to determine the direct, indirect (for both fortitude and COVID-19-related worries) and moderating effects is shown in Figure 1.
Figure 1: Testing the direct, indirect and moderating effects of worries and fortitude on psychological distress

Note. Rectangles are observed variables and ellipse is a latent variable.

The model in Figure 1 provides for a predictor variable (COVID-19-related worries) and a presumed mediator (fortitude). The outcome variable is a latent variable (psychological distress) that is defined by the two indices of depression and hopelessness. The model also contains an interaction term (worries X fortitude) that tests the potential moderating role of fortitude. Finally, gender is included as a covariate, because there were significant gender differences in the levels of depression. An alternate path analysis used fortitude as predictor and worries as mediator to test the indirect effects of fortitude on psychological distress.

The results of the structural equation modelling related to Figure 1 are shown in Table 2.
Table 2: Direct and indirect effects of COVID-19-related variables on psychological distress

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>SE</th>
<th>β</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Worries</td>
<td>.074</td>
<td>.014</td>
<td>.25</td>
<td>[.132, .358]</td>
<td>.004</td>
</tr>
<tr>
<td>3. Fortitude</td>
<td>-.202</td>
<td>.022</td>
<td>-.74</td>
<td>[-.808, -.648]</td>
<td>.008</td>
</tr>
<tr>
<td>4. Worries X Fortitude</td>
<td>.004</td>
<td>.001</td>
<td>.15</td>
<td>[.049, .239]</td>
<td>.004</td>
</tr>
<tr>
<td><strong>Indirect Effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Worries(^a)</td>
<td>.012</td>
<td>.004</td>
<td>-.08</td>
<td>[-.158, .017]</td>
<td>.068</td>
</tr>
<tr>
<td>2. Fortitude(^b)</td>
<td>.007</td>
<td>.004</td>
<td>.03</td>
<td>[-.003, .063]</td>
<td>.061</td>
</tr>
</tbody>
</table>

*Note.* \(^a\)Worries as predictor, fortitude as mediator
\(^b\)Fortitude as predictor, worries as mediator

Table 2 indicates that each of the direct effects was significant because zero falls outside the confidence intervals and \(p < .01\) in all instances. These findings indicate that an increase in COVID-19-related worries is associated with an increase in psychological distress (\(β = .25\), \(p = .004\)). The direct negative association of fortitude with psychological distress (\(β = -.74\), \(p = .008\)) supports the health-sustaining hypothesis in that increased levels of fortitude are associated with decreased levels of psychological distress. However, the indirect effects were not significant, which indicates that neither fortitude nor worries has a mediating effect. The interactive effect was significant (\(β = .15\), \(p = .004\)); however, the moderation effect occurred in an unexpected direction in that the interaction of fortitude with worries led to an increase in psychological distress, rather than a decrease. In addition, the factor loadings of depression and hopelessness on psychological distress were both significant (hopelessness: \(.71\), \(p = .005\); depression: \(.80\), \(p = .006\)), which demonstrates that the latent variable of psychological distress adequately represents these variables.

To understand the nature of the interaction between the predictor and the moderator, Cohen et al. (2003) has suggested the calculation of two regression lines: one for those with high fortitude (at or above the 75th percentile, \(n = 92\)) and one for those with low fortitude (at or below the 25th percentile, \(n = 85\)). The graphs of these regression lines for the relationship between worries and psychological distress for the fortitude subgroups are shown in Figure 2.
Figure 2: The regression of psychological distress on COVID-19-related worries for those with high and low fortitude

Figure 2 indicates that, although those with high fortitude experienced less psychological distress in relation to COVID-19-related worries, the regression line for those with high fortitude was steeper (slope = 0.49) than for those with low fortitude (slope = 0.19). There was also a significant positive relationship between worries and psychological distress for those with high fortitude ($r = 0.43, p = .022$), whereas this relationship was not significant for those with low fortitude ($r = 0.18, p = 0.165$).

**DISCUSSION**

The current study investigated COVID-19-related worries, hopelessness and depression among young adults in South Africa and the influence of fortitude on psychological distress. There were several significant findings. First, unprecedented levels of psychological distress were reported in the current sample. The levels of hopelessness and depression exceeded those documented in the existing literature in other contexts (Giuntella et al., 2020; Hacimusalar, Kahve, Yasar, & Aydin, 2020). The elevated levels may be related to the drastic changes that young adults in South Africa experienced as a
consequence of the COVID-19 pandemic. These changes include the abrupt closure of universities and rapid transition to online modes of learning in resource-constrained conditions; disconnection from peers and other social support networks due to home confinement; financial pressures; a declining labour market and uncertainties about the future. In addition, a significant portion of the South African population live in community contexts characterised by poverty and over-crowding, which may aggravate worries about infection and one’s capacity to engage in protective behaviours. These factors can heighten despair and increase hopelessness and depression (Cao et al., 2020). Furthermore, the current COVID-19 outbreak in South Africa is occurring against the backdrop of chronic disease epidemics, such as HIV and tuberculosis; and the prevalence of these chronic diseases could aggravate worries about the potential impact of becoming infected with COVID-19; and thus produce a sense of despair (Kim, Nyengerai, & Mendenhall, 2020).

Second, the study found gender differences in psychological outcomes, similar to previous studies (Özdin & Bayrak Özdin, 2020; Rossi et al., 2020) with women reporting higher levels of depression than men. These gender differences may be due to disruptions in the social support networks that women typically use for coping. Gender role socialisation often leads women to prioritise affiliations with friends and family and disruptions to these relationships due to home confinement and social distancing protocols can lead to loneliness, which is associated with depression. In addition, the rates of gender-based violence have significantly increased in South Africa during the pandemic (Adebayo, 2020) and this increase may result in women experiencing a decreased sense of safety and heightened sense of threat at home, which can lead to feelings of hopelessness and despair.

Third, fortitude was found to have a significant direct effect on psychological distress, irrespective of the level of COVID-19-related worries. Specifically, increased fortitude was associated with decreased levels of psychological distress, regardless of personal worries about infection or broader fears about the social and economic implications of the COVID-19 pandemic. This finding lends further support to prior studies conducted by Padmanabhanunni (2020) and Pretorius et al. (2016) that have attested to the potential health-sustaining role of fortitude. Fortitude was also found to have a significant moderating effect. The moderator can either reduce the impact of the predictor on the outcome as a buffering effect or increase the impact of the predictor as a magnifying/aggravating effect (Francoeur, 2011; Nye & Witt, 1995). In this study, fortitude had a magnifying effect. The results of subgroup analysis (those with low and high fortitude) indicated that the relationship between COVID-19-related worries and psychological distress was stronger for those with high fortitude than for those with low fortitude.
There are several explanations for the above finding. The COVID-19 pandemic is a highly complex stressor, because it is characterised by significant uncertainty about disease progression, life-threatening environmental conditions, prolonged exposure to anxiety-provoking information (global statistics on infection and death rates), potential loss of loved ones, financial insecurity, disrupted daily routines and ways of life and an actual physical health threat (Gruber et al., 2020). The pandemic has fundamentally impacted perceptions of personal safety and security and the predictability of daily life. In addition, COVID-19-related prevention measures (social distancing, quarantine and stay-at-home directives) have inadvertently reduced access to social resources that are important for maintaining psychological health. In high-income countries, digital technologies were used to circumvent the restrictions on in-person social contact. However, developing countries, like South Africa, have limited access to digital technologies and internet connectivity; therefore, digital modes of social engagement may not be possible. Given the multiple and unparalleled stressors of the COVID-19 pandemic, it is plausible that even individuals who have high fortitude would experience increased worries and distress.

In the current study, there was a stronger relationship between worry and psychological distress for those high in fortitude compared to those low in fortitude. However, it needs to be underscored that for those high in fortitude these levels of worry and distress were still relatively lower compared to those low in fortitude. In explaining the former finding, it is necessary to draw on the fortigenic theory, in terms of which fortitude is derived from adaptive cognitive appraisals of self, family support and other significant sources of support. Individuals with high levels of fortitude tend to appraise themselves as capable of managing life stressors and use active, solution-focused strategies (being task-oriented, planning ahead and seeking advice and support: Prentice et al., 2020). Under pandemic-related conditions, it is probable that these coping strategies do not yield similar results, which may aggravate distress. Furthermore, typical sources of social support, including family and friends, are under actual physical threat due to the probability of infection; and it is possible that awareness of the very real potential for loss of loved ones may heighten worries among those with high fortitude. The nature of the worries (loss of loved ones, fears about family contracting the virus, etc.) can impact the sources of fortitude, which may further explain the aggravating role of fortitude.

In sum, fortitude on its own has a direct negative association with psychological distress. However, when considered in conjunction with COVID-19-related worries, fortitude has an aggravating effect on the relationship between such worries and psychological distress.
LIMITATIONS

The study was cross-sectional, which limits the ability to draw conclusions regarding causal relationships. Nevertheless, the findings on adverse mental health outcomes associated with the COVID-19 pandemic are consistent with the existing international literature (Groarke et al., 2020; Luchetti et al., 2020). The survey was delivered electronically, which could restrict participation to those who had internet connectivity. However, reports from UWC Communications (2020) indicate that 94% of the student body at the University had been able to engage with electronic modes of communication. The study also used random sampling, which increases the generalisability of the findings.

CONCLUSION

To the authors’ knowledge, this is the first study to investigate COVID-19-related worries, depression and hopelessness among young adults in South Africa. The unprecedented levels of psychological distress observed among the current sample suggest a mental health crisis and the need for psychological intervention strategies to be incorporated into pandemic-related mitigation plans. The health-sustaining role of fortitude has been confirmed, which suggests that interventions aimed to increase positive appraisals of self, family support and social support could potentially help people cope with the mental health consequences of COVID-19. Several studies have demonstrated that the FORQ measures a construct that is changeable (De Villiers & Van den Bergh, 2012; Laureano, Grobbelaar, & Nienaber, 2014; Van Schalkwyk & Wissing, 2013). Therefore, modification of fortigenic appraisals, through cognitive restructuring interventions, could affect an individual’s wellbeing and adjustment in the context of the COVID-19 pandemic.

REFERENCES


Navigating and Reimagining Community Engagement amidst COVID-19

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ABSTRACT
Community engagement is a critical manifestation of a humanising approach on how to respond to various psychosocial and structural violence challenges in the context of a pandemic. Community engagement within the context of the current global coronavirus pandemic (COVID-19) requires creative and innovative responses. Institutions have had to reconfigure their community engagement due to restrictive measures instituted by governments to curb the spread of the virus. This paper aims to reflect on the conversations and experiences of community activist researchers in implementing creative ways of engagement to address pertinent psychosocial and structural violence issues affecting communities during COVID-19. Through a qualitative reflexive approach, we identified the following themes: (1) Challenges in community-engaged research during a pandemic; (2) Structural violence and psychosocial issues; and (3) Innovative opportunities to bridge gaps and confront community realities. The pandemic has produced challenges but has also allowed for opportunities to reimagine community engagement. It has created opportunities and novel ways of collaborating with multisectoral social actors to address the psychosocial challenges during the pandemic and to remain actively engaged with communities.

Keywords: Community engagement, community activist researchers, COVID-19, conversations, reflections

INTRODUCTION

The novel coronavirus, commonly referred to as COVID-19, has drastically changed the way that individuals, communities, businesses and society operate. Due to a rapid increase in infections, the South African government was compelled to implement a national lockdown, leaving many resource-constrained communities and their members in crisis, as existing social ills and inequalities became even more apparent during this unprecedented time (Al Jazeera, 2020; Shaban, 2020). Mutisi (2020), however, emphasises that people are located at the centre of this crisis, and should therefore not be forgotten in any decision-making and strategic planning, and that these activities should be aligned with community interests. In this regard, Black (2020) and others (Lazarus, Bulbulia, Taliep, & Naidoo, 2015; Tindana, De Vries, & Kamuya, 2020) highlight the necessity of recognising the value of focused community engagement in safety and health prevention and promotion strategies, which should be congruent with and responsive to community needs and priorities. Consequently, it is necessary for institutions, relevant policymakers and government structures to engage directly with communities and civil society, and to keep a finger on the pulse of community needs and assets that can be mobilised in under-resourced contexts, particularly during times of crisis.
Community engagement (CE) can be defined as an umbrella term that encapsulates academic activities in partnership with communities and is guided by key principles including: respect for community dynamics, aligning the research agenda with the needs of the community, democratising knowledge production through the inclusion of community members in all phases of the research project, and a focus on strengthening and sustaining communities (Glandon, Paina, Alonge, Peters & Bennett, 2017; Lazarus et al., 2015; Lazarus, Taliep, Bulbulia, Phillips, & Seedat, 2012; Reynolds & Sariola, 2018).

There are various models of operationalising and implementing CE and the model chosen usually depends on how CE is conceptualised by an institution (Bhagwan, 2017; Hashagen, 2002; Reynolds & Sariola, 2018). This paper aims to reflect our experiences as community activist researchers at the University of South Africa’s (UNISA) Institute for Social and Health Sciences (ISHS) and the South African Medical Research Council (SAMRC) and UNISA’s Masculinities and Health Research Unit. Our conversations and reflections on CE in this paper are embedded in the Transformational Community Engagement Model, which serves as a guide to our research unit’s community engagement work (Taliep, Lazarus, Bulbulia, Ismail, & Hornsby, 2018).

The CE model set out by Taliep et al. (2018) can be seen as a transformational approach to engagement that draws on a critical public health framework alongside the principles of a Community-Based Participatory Research (CBPR) approach. This transformational model of engagement is differentiated from conventional engagement through mutually beneficial processes, necessitating authentic discussion, cooperation, critical reflexivity, co-construction and co-learning, as well as co-ownership of projects. In concordance with the principles of CBPR, this process of engagement echoes a collaborative participatory paradigm that underscores building on existing strengths and resources within a community, praxis, and optimum participation of community members in decision-making processes throughout the research process (Taliep, 2016; Taliep et al., 2018). This form of engagement further stresses an intentional focus on social and epistemic justice, reflexive engagement of power differentials, tackling issues of race, racism and social class, engendering agency, and fostering sustainability (Lazarus et al., 2015; Taliep, 2016; Taliep et al., 2018). Moreover, this model affirms communities having agency to initiate change and transformation, autonomy, and sustainability.

The value and benefits of CE have been recorded by various studies. In South Africa, Bhagwan (2017) found that CE allows academic institutions to get in touch with communities, which are often very removed from the external environment. Rather than imposing interventions on communities, CE scholars create a space for co-designing interventions based on community needs, and ensure that the community’s voice is central when developing solutions; learning takes place bi-directionally (i.e. both
academics and communities learn from each other); and it provides a platform where local knowledge outside of academic institutions is valued (Bhagwan, 2017). In a study by Musesengwa and Chimbari (2017) with community members, schools, health workers and policymakers in Zimbabwe and South Africa, participants acknowledged that they felt respected to have been part of the decision-making processes and that the continuous canvassing of their opinions in the various stages allowed for true engagement which, in turn, acknowledged and enhanced their agency (Musesengwa & Chimbari, 2017). As such, CE allows for a space of co-learning, where both communities and researchers have something to offer to each other, and ultimately aims to foster community ownership and sustainability. The importance of involving community members in ensuring the success of initiatives that aim to build and transform community contexts has been highlighted by many CE scholars (Brown-Luthango, 2013; Lazarus et al., 2015; Taliep, Bulbulia, Lazarus, Seedat, & the Building Bridges Team, In Press). Specifically, these authors raise the importance of relationship building and consultation with the community which, if neglected, can lead to negative outcomes for community members as well as research institutes. To have a successful university-community partnership, there needs to be mutual beneficence. Brown-Luthango (2013), for example, highlights a major limitation in their project as the lack of consultation with members of communities and the gap between the academic institution and community that was never bridged. This alludes to the imperativeness of community involvement in every stage of the research process, managing power imbalances, and ensuring that the community receives (sustainable) tangible benefits from the project for meaningful collaboration between universities and communities to occur (Brown-Luthango, 2013). Community members should thus be viewed as more than mere research participants in a study; they have power and should be centrally involved in the production of knowledge.

During the pandemic, trust as a value of CE became paramount in addressing the felt needs of the community in this time. Holzer, Ellis and Merrit (2014) contend that engaging with a community is a sign of respect and acknowledgement for community interests, needs and values which could lead to enhanced community trust, an increase in participation and an improvement in the uptake of research results. During the Ebola epidemic in Liberia, Barker et al. (2020) found that CE enhanced health system resilience and that it assisted in managing the health crisis. The authors found that true CE assisted in building trust among communities and ultimately led to a more effective response to the crisis. Involving communities strengthened health systems by providing important information, strategies and feedback to improve the ability of the system to respond to the immediate needs of the community during the pandemic (Barker et al., 2020).
Another important aspect of CE is establishing and maintaining a presence in the community, which normally requires face-to-face interaction (Magaço et al., 2020; Taliep et al., 2018). In this regard, Bowen (2011) indicates that a community’s unfamiliarity with a research institution could serve as a barrier to full participation, and Lazarus et al. (2012) found that regular face-to-face communication facilitates participation and active involvement of community. Having a face-to-face presence in the community and attending events that are important to community members creates a space for engagement and enhances research efforts (Bowen, 2011; Scruby, Canales, Ferguson, & Gregory, 2017). This facilitates relationship-building, mutual respect and trust between researchers and community members – a vital element for such collaborations. Regular face-to-face meetings with community colleagues and network structures further provide a safe space where everyone can share their experiences and challenges and where updates can be given on community projects, successes and collective planning can occur (Taliep, Ismail, Bulbulia, & Louw, In Press).

In light of the challenges and possibilities for CE during COVID-19, this paper aims to present the personal experiences of our community activist research team. The team consists of four members: a novice researcher (research intern), two community psychologists and the community engagement coordinator of the research institute. Three of the members are experienced community researchers who have been active in the field for a significantly longer period than the novice researcher (15–25 years of experience). As activist scholars, we are actively engaged with communities and the current realities they encounter. We are committed to the ethics and basic values of social justice, including being attentive to structural and social inequities and bridging the separation between theory and practice and between researcher and participant (see Lennox & Yildiz, 2019). Our work is therefore embedded in the values and principles of CBPR, placing community at the centre, and foregrounds community engagement throughout the research process.

COMMUNITY PROFILE

Our CE activities mainly revolve around communities located in the Strand, Western Cape, South Africa, and prior to the lockdown, required us to physically meet regularly with community colleagues. The Strand area consists of a population of about 55 558 residents (16 109 households), of which 22.4% are children (aged 0-14) and 10.5% of residents are considered elderly (65 and older) (Statistics South Africa, 2011).
OUR APPROACH TO COMMUNITY ENGAGEMENT

Our community-engaged work is primarily located within the research unit’s Erijaville Demonstration Programme and we have been working collaboratively with community colleagues (nine community members who have been part of our CE team for the past five to ten years and our network partners) to develop the Building Bridges youth intervention and Building Bridges non-profit organisation (NPO) (see Cutts et al., 2016; Lazarus et al., 2012; Taliep et al., 2020). The programme is primarily geared toward youth violence and focuses on the promotion of safety, peace and health. Over the last few years, we have been actively engaged with a core group of community members (the community research team) and have been physically present on a regular basis to ensure a presence in the community. These operations include, but are not limited to, weekly team meetings, the attendance and hosting of training and capacitation workshops, awareness campaigns planned and co-hosted by us and our community colleagues from the Building Bridges NPO, meetings with various community stakeholders, and a monthly community network meeting as part of the Local Network of Care (LNOC) Strand, which we co-host. We also, prior to the lockdown, planned the network’s activities for the year 2020, which included monthly meetings and training and capacitation workshops. Our weekly meetings commence with a check-in session, which creates a space for all members to share and hear concerns, to address emerging issues and challenges, and collectively plan for future events (Isobell, Lazarus, Suffla, & Seedat, 2016; Taliep et al., 2020). As part of our continuous CE and sustainability planning and capacity, we envisaged a variety of capacity development training as well as the evaluation of the programme itself.

This, however, has not been possible during the COVID-19 lockdown and has required our team to change our CE strategy. Our conversations and reflections will attempt to outline some of the challenges experienced by the research team, with specific reference to CE during COVID-19. The paper will also focus on how some of these challenges were overcome and how our team adjusted our CE strategy. It is important to note that the aim of our CE work did not alter, though our way of engaging with the community did, and our work was still guided by the principles of our CE model. The paper will therefore further attempt to explore new and innovative ways of carrying out community engagement under restricted circumstances through our reflections.
COMMUNITY ACTIVIST RESEARCHERS: CONVERSATIONS AND REFLECTIONS

Our reflections are structured according to themes based on our experiences of CE during this time. These themes are: (1) Challenges in conducting community-engaged research; (2) Structural violence and psychosocial issues; and (3) Innovative opportunities to bridge gaps and confront community realities. Our conversations took place primarily via project meetings on Zoom, Microsoft Teams and in conversations via WhatsApp as these were our only modes of communication during lockdown. Our meetings focused on planning and managing ongoing community projects, as well as navigating our way through the pandemic while working from home. Our personal conversations among our community activist research team, as well as our continuous communication with our community colleagues, were thus what contributed to our reflections and collective identification of the most pertinent themes. It is of importance to note that we had an existing relationship with the community prior to the pandemic and this allowed CE to occur more smoothly since we had regular contact with community members and stakeholders. It has been argued that pre-existing programmes that promote ongoing communication and relationship-building facilitate engagement during times of crisis (Cattapan, Acker-Verney, Dobrowolsky, Findlay, & Mandrona, 2020). These themes will show the value of continuously working with communities and how both a novice researcher and more experienced researchers re-imagined CE during COVID-19.

CHALLENGES IN COMMUNITY-ENGAGED RESEARCH DURING A PANDEMIC

There is no perfect guide that could have prepared us and other academics and collaborating communities for the coronavirus and its consequences. The pandemic has us in what Roy and Uekusa (2020) characterise as a scholarly challenging time and, as part of this, social distancing has caused its own challenges for many researchers, including a lack of daily interaction with colleagues and the inability to engage with gatekeepers, community members and stakeholders. It has also prevented scholars from entering communities in the traditional manner (Greeff, 2020; Hendrickson, Anderson, Schaumer, Amador, & Vieira, 2020). Due to the restriction on movement put in place as part of the national lockdown, in-person physical CE has been hampered, and we have encountered various challenges (as have many community stakeholders) in engaging and reaching community members and the colleagues we work with. Many academic institutions were required to physically close during the national lockdown. Academic operations have continued remotely, and staff and students have been
required to work from home. The situation also introduced the risk of additional miscommunication due to distance and not being able to physically meet and clarify misunderstandings.

Our community engagement, as a team of researchers, has thus undoubtedly been affected. Questions such as the following arose:

1) How do we maintain operations without being able to physically meet and discuss problems?
2) How do we assist in bringing forth marginalised voices when the pandemic has created a “loud silence” where inequalities are highlighted but not addressed?
3) How, under new circumstances, do we maintain the strong relationships that were previously established?
4) How do we valuably engage with our community colleagues and facilitate the process of co-learning and knowledge production when we, as researchers, have all the resources readily available but when many of our community colleagues do not have access to electricity, internet, smartphones or laptops?
5) How do we assist in mobilising community resources, knowing that we are far removed from the communities concerned?

Similar to what was experienced by Magaço et al. (2020), many of our research activities had to be deferred. Some of these activities include the final outcomes evaluation of the Building Bridges Mentoring Programme (BBMP), as well as the evaluation of our Transformational Community Engagement Model. We could not continue with “business as usual” or collect data from people whose primary goal was to get a meal for the day. With the social crisis brought on by the pandemic, it was necessary for our research team, along with our community colleagues, to re-think our CE research and prioritise relief initiatives, while still adhering to some form of community engagement.

STRUCTURAL VIOLENCE AND PSYCHOSOCIAL ISSUES

The untimely advent of the COVID-19 pandemic has laid bare the pre-existing injustices and inequities that disadvantaged communities in South Africa have been experiencing for generations. The result of this has been that these communities now face a double onslaught and their people bear the brunt of the pandemic’s effects. The communities with whom we engage were classified as ‘coloured’ by the apartheid regime. Structural violence is visible in the everyday existence of these communities.

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2 The term ‘coloured’ refers to one of the racial classification categories, specifically referring to individuals of mixed heritage, used under the apartheid regime. Although still socially recognised, the use of the term in this paper is purely for research purposes.
characterised by various disparities, lack of access to service delivery, and concomitant socio-economic and spatial inequalities (Taliep, Lazarus, Seedat, & Cochrane, 2016). Galtung (1969, p. 171) defines structural violence as violence that is built into or constructed as part of the very “structure and shows up as unequal distribution of power and consequently unequal life chances”.

Low-income communities, within which our CE activities occur, are plagued by unemployment, poverty, limited infrastructure and a high incidence of injuries (Taliep et al., 2020; Van Niekerk & Ismail, 2013), which has contributed to the psychosocial issues being experienced within them. These issues, however, have become even more visible during the COVID-19 lockdown. Navigating structural violence had already proven to be difficult under ‘normal circumstances’ (prior to the pandemic) but has intensified due to the pandemic. Many people in the community became unemployed due to establishments being forced to close down during the strict lockdown (for example, Early Childhood Development centres [ECDs], or people being laid off from work. This resulted in an abrupt lack of income to support themselves and their families. One of our LNOC members, an ECD forum coordinator, indicated that the crèches have been closed since the beginning of lockdown and that teachers had not been paid and were struggling to survive. [Name] indicated that she must connect with us by providing the contact details of the teachers for food vouchers. The lockdown also caused many people to spend more time at home, which in itself brought on many challenges.

Adhering to lockdown measures was often, and at best, impossible for some. While the home was a means of protection against the virus, the dwellings in some parts of the community have quite confined spaces (for example, shacks) that often need to house more than one family. They are, therefore, not conducive under such restrictive circumstances such as the lockdown. The dwellings are also short on space, such as backyards or front gardens, for recreation. There were often inconsistencies between the government’s instructions under lockdown and the reality of the community members (for example, having to wash/sanitise hands regularly or wearing masks, but not having access to running water or being unable to afford personal protective gear). Thus, people in these communities were not afforded the same comfort and safety which this space provides to others.

As community activist researchers, we witnessed these harsh realities and acknowledged our position of privilege and being able to work remotely from home. We, along with our community colleagues, therefore tried to address some of these structural challenges by continuously engaging with the
community. Our efforts during this time, albeit remotely, were thus focused on alleviating some of these challenges.

Drawing on our existing community collaborators, we set up numerous virtual engagement meetings. These, initially, were beset by many obstacles that required innovative solutions (see below). At one of our virtual meetings, a community member noted that, *the first imperative would not be adhering to lockdown regulations, but rather not to starve because many children, who normally were fed at schools, and the elderly were going hungry.* Spurred on by this, we collectively initiated a plan to focus on food security and started four soup/food kitchens in the areas in which we worked.

Within the confined spaces, loss of employment and gender-based violence (GBV) emerged as key challenges to be faced during the COVID-19 lockdown in many impoverished communities. The unintended consequence of confining victims of domestic violence to their homes was that these individuals were then at the mercy of their abusive partners. Through our engagements with the Building Bridges NPO in Strand, it was noted that women active in their respective communities were not given the opportunity to voice their daily struggles or express the anxieties they were experiencing as they carried out their emotionally intensive work. Collectively, we decided to co-host a virtual grassroots community conversation (we usually host one every quarter), this time involving women from multiple communities and specifically focusing on COVID-19 challenges and GBV. This workshop/conversation was very successful, and the attendees requested that we host another conversation.

**INNOVATIVE OPPORTUNITIES TO BRIDGE GAPS AND CONFRONT COMMUNITY REALITIES**

CE remains a vital tool to be used to ensure an effective response from communities and to address the health and safety of communities (Black, 2020; Oxfam, 2020). Notwithstanding the loss and devastation of the pandemic, as well as the disruption it has caused in various areas of life, we concur with Mashiapata and James (2020) that COVID-19 has presented new possibilities and opportunities for innovation and has highlighted the important role of universities in the creation and implementation thereof. This has provided an opportunity for the hosting of a range of national and international online seminars, or webinars, by various organisations and institutions, in addition to fast-tracking new and
innovative means and technologies of engaging with communities. The subsequent sections will explore initiatives that we have used to guide continued CE activities under the COVID-19 lockdown, as well as challenges encountered and suggestions for community engagement during COVID-19.

Ground-up approach

Given the conventional way we have performed CE in the past (guided by the principles of CBPR) and through the respective reflections of our research team, it was important for our team to continue engagement by means of processes that were reciprocally beneficial. This required genuine, trustworthy conversations, collaboration, cooperation, critical reflexivity, co-learning, co-creation of solutions, and the co-ownership of initiatives (Lazarus et al., 2015; Taliep et al., In Press). In addition, several studies have outlined the mistrust communities often have of researchers as some exploit communities for information with no regard for their needs, values and beliefs, and without any tangible benefits for the community (Brown-Luthango, 2013; Holzer et al., 2014; Lazarus et al., 2015; Musesengwa & Chimbari, 2017). Building trust and relationships, and maintaining that trust and relationship with a community, is vital. Keeping the principles and importance of CE in mind, we strongly motivate that a quick and effective response to any social crisis requires continuous CE to build trust and gain community perspectives, as it is often the most vulnerable groups that are most affected, even if this approach requires us to make use of complex online platforms (Cattapan et al., 2020).

We have found that, in order to maintain our CE activities during this time, it has been important and necessary to employ digital platforms. James (2020), a representative from an institution’s community engagement division, emphasises this, indicating that, as we are unable to do work on the ground, it has been necessary to create a strong digital presence. This includes online meetings and seminars, social media, electronic communication and the facilitation of online workshops.

Initially, we took some time to find our feet while working from home, at the same time remaining in contact with our community colleagues, as the lockdown called for immediate responses and relief initiatives. We had to maintain a mutually beneficial relationship where co-learning could take place so as to not hamper the growth and sustainability of existing initiatives. It was necessary to decide collectively which platform would be best to communicate with – a platform which would be suitable for our community colleagues and for us. Prior to video-call platforms becoming available to us, all communication took place via WhatsApp. As the WhatsApp group chats (with both the NPO and
LNOC) already existed prior to lockdown, it was easier to continue using this platform to communicate. However, this brought about its own challenges.

Relief initiatives had to commence as soon as possible, and it was thus necessary to separate WhatsApp groups for the various initiatives (for example, separate groups for the soup kitchen, financial matters, NPO activities and so on) to prevent any interference between groups and to aid in staying focused on the task at hand. The use of WhatsApp communications alone also created conflict among group members, and it was decided that a virtual face-to-face meeting would need to be held in order to address any issues arising and to plan an adjusted strategy for the continuation of the programme. The NPO team indicated that their preference would be to come together via Google Meet. Institutionally, however, we were compelled to use safer platforms, such as Microsoft Teams and Zoom. We provided training on the use of these platforms and our engagement has since continued on these platforms. We have since had weekly meetings with the NPO team during which updates are provided regarding the operations of the NPO, and where any challenges or issues are addressed. Despite initial challenges, these meetings have proven fruitful as the team has been able to discuss the way forward in respect of the activities of the NPO.

The community network’s WhatsApp group has also remained active. Here, requests, updates, job opportunities, information regarding the community and relief initiatives continued to be shared by various organisations and community members. This allowed us to be cognisant of what was happening in the community and to know where we could assist while being unable to be there physically. We have also managed to re-establish our monthly meetings via the Zoom virtual meeting platform. The use of this platform was collectively decided upon among network members through WhatsApp messages and emails. This has allowed our communication and engagement to extend beyond the WhatsApp platform. It was also decided that all training and capacitation workshops would take place via Zoom. Although attendance at the virtual meetings has been small, the WhatsApp group has remained active. These platforms have facilitated continuous engagement with community colleagues under the current circumstances.

Notwithstanding the benefits, some barriers have made these platforms difficult to use for community members. Various authors speak of the digital divide which has highlighted contextual issues that may complicate the effectiveness of digital communication. This includes high data and airtime costs, devices with software and hardware inadequate to use online meeting platforms, poor internet connections as well as unreliable electricity connections (Cattapan et al., 2020; Greeff, 2020; Tindana...
et al., 2020). Initially, some attendees were unable to join the meetings due to not having enough data to connect to the platforms, while electrical load shedding caused unstable internet connections or, in some cases, an inability to connect at all. Some of the attendees on the online platforms had never previously used this type of technology and required specific training on how to do so. In such instances, we took the attendees through the steps to download and use the applications, and the team decided that we would connect 10 to 15 minutes before the start of the meeting to sort out possible technical difficulties. Our unit provided participants with data vouchers, and data mobile modems for the NPO. The NPO was also successful in securing a free Wi-Fi router and data for their office. Aware that not everyone might be able to participate online and that this might exclude important groups from our meetings (Cattapan et al., 2020; Tindana et al., 2020), we circulated minutes to those who could not attend (on WhatsApp and via email) to include them in some manner. These barriers were indicative of the limited technological resources and infrastructure and, as noted by James (2020), it is important to network with various community stakeholders in order to communicate with communities who have limited access to the internet, phones, Wi-Fi and laptops.

Despite these challenges, often indicative of the resource-constrained context we work in, CE and operations have been able to continue. Workshops have been held and community conversations have been offered by the NPO with these being attended by community members and someone from our research team. These workshops were based on information provided by our community colleagues. A need was identified within the NPO for improved workplace etiquette, internal communication and dealing with emotions within the workplace. Our research team then offered to host these workshops with the NPO team. The NPO themselves also hosted virtual community conversations based on the need expressed by community members as to how to deal with the challenges of COVID-19 and GBV.

This accentuates the importance of learning taking place bi-directionally, as we learn from our community colleagues by engaging with them. Co-learning further takes place through planning together, learning from our mistakes, and finding solutions collectively with our community colleagues. There have also been offers from community colleagues to host computer skills training. This is a beacon of hope for our CE as community members can identify their own needs, where growth is possible, where we can assist and how they can assist us in connecting with community members. We learnt that, despite COVID-19, we could still make a difference through collective CE.
Although our team had a turbulent start to establishing a virtual connection with our community colleagues, as the lockdown period was extended and the wider team became accustomed to our new, adjusted way of working, some “normalcy” set in. The use of digital platforms has allowed us to stay in contact and has provided an opportunity for digital capacity development, as well as continuity of thought in terms of research process and praxis.

**Mobilising and consolidating assets and resources**

In addition to food relief initiatives, as there have been financial constraints on many households during this time, our team also developed an information sheet concerning nutrition on a very low budget (Louw, Taliep, Ismail, & Bulbulia, 2020). The information aimed to provide community members with a “shopping list” for healthy, nutritious food items that would be affordable and could go a long way. Our community colleagues also identified that many community members struggled to apply for the Unemployment Insurance Fund (UIF). We then collectively decided to develop a flyer detailing the steps of the application process. These flyers were then distributed within the community at focal points, i.e. the soup kitchens. As suggested by one of our NPO community colleagues, the distribution of information while feeding the community was aimed at education and creating awareness. Although it has been a matter of trial and error, both for our team and for our community colleagues, we believe that our collective efforts thus far, have allowed us to explore new ways of engaging with communities and, with the necessary commitment and communication, could provide sustainable CE initiatives for the future. Another institution has also indicated that funds that were reserved for travelling, catering and venue bookings will now be used for digital CE activities (James, 2020).

**Participatory coordination and communication**

Various studies have highlighted the importance of communication during times of crisis, even more so during a pandemic (Vaughan & Tinker, 2009). As stated by Ahmed and Palermo (2010), for CE projects to continue effectively, bi-directional continuous communication needs to take place. Communication also allows any myths, stereotypes, fears and misinformation surrounding the virus to be diminished (Goodwin, Haque, Neto, & Myers, 2010) and is deemed more effective if it is not rooted in misconceptions (Centers for Disease Control and Prevention as cited in Vaughan & Tinker, 2009). As stated by Holzer et al. (2014), communities are the best spokespeople when it comes to the concerns and issues that affect their members. Another important aspect of communication under pandemic
conditions is being aware of the different phases of that pandemic and being aware what information should be communicated and in which phase (Reynolds & Quinn, 2008; Vaughan & Tinker, 2009). Communication has always been an important tool for us as community activist researchers when engaging with communities under conventional circumstances, but even more so while working remotely.

A further important aspect that should be emphasised is the compatibility of communication strategies and messages. To ensure that vulnerable populations effectively understand and adhere to health and safety messages that are communicated, the messages need to be fit for information priorities, reasoning strategies and cultural beliefs of the affected community (Vaughan & Tinker, 2009). Additionally, Kapucu, Garayev and Wang (2013) contend that not having sufficient technological capacity could hinder the effective management of disasters and could cause detachments from network actors, updates and activities. It was thus important for our team to have virtual communication (in the absence of being able to meet physically) with our community colleagues to continue to practice meaningful CE and guide each other through the new way of working while also keeping in mind the structural and technological deficits that might be present.

Aside from online platforms, we have also made use of online message tools to continue engagement. As was done by Goodwin et al. (2010) during the severe acute respiratory syndrome (SARS) outbreak, we used various communication techniques to empower and mobilise communities in Strand. This included the dissemination of updated COVID-19 information in the language of local communities and the development and distribution of fridge magnets (via the NPO) with a safety message and emergency numbers (for example the GBV hotline and the National COVID-19 hotline). Our research unit has provided various messages on social media (Facebook and Instagram) and in our community WhatsApp groups which have been distributed among our community groups and colleagues. Schonfeld, Meadows and Harington (2020) argue that social media has an important role to play and that choosing the appropriate channel for your demographic is vital. It was, therefore, important to share our messages on WhatsApp, in addition to the other two platforms, as more of our community colleagues have access to the WhatsApp platform and do not necessarily have Facebook or Instagram accounts.

The messages focused on various aspects of health, safety, and well-being for families with young children during COVID-19 (CARP Facebook, 2020; CARP Instagram, 2020). A pandemic has different phases and messages therefore need to be adapted accordingly (Reynolds & Quinn, 2008). Our
messaging started with the dissemination of tips on how to explain the circumstances around the pandemic to children, how to keep safe and how to create daily routines while children are still at home. Messages then had to shift to the return to school (how to keep safe while at school and how to navigate emotions once returning to school) as schools gradually started to reopen under strict measures during the lockdown. Messaging has thus assisted in communicating with communities, but it has had to remain flexible, depending on the communication provided by the government and the current circumstances.

**Strengthening relationships**

As technology and more advanced forms of digital communication are restricted in some communities, it is suggested that contact be kept with community members, such as community leaders, influencers or faith-based groups that do have access to these platforms; they can ultimately serve as key information providers (James, 2020; Oxfam, 2020). Oxfam (2020) further stresses the fundamentality of advocacy efforts and the role CE plays when doing such work. The aim is to heighten community voices and these efforts should thus be based on feedback and consultation with communities that are most affected by the pandemic (Oxfam, 2020).

The LNOC Strand consists of a network of organisations and community members that aims to strengthen organisational capacity to address local challenges and improved service delivery to the community (Gordon, 2018). The network and our network partners, many of whom actively operated and assisted within the community during this time, served as key informants as to what the community needed, what efforts were being made, and where we could collectively assist. In addition to maintaining and strengthening relationships via digital platforms, the LNOC collective found innovative ways to ensure that support and essential care was provided to vulnerable groups through the coordination of task teams, the operation of soup kitchens and distribution of food hampers (Taliep et al., In Press). Furthermore, the Building Bridges NPO, despite all the challenges brought on by the pandemic, found other ways to continue their engagement activities to assist the community where possible and to continue reaching the objectives of the NPO. The Building Bridges team also resorted to virtual platforms, not only to meet with us as their community colleagues but also to navigate their activities within the NPO. As part of addressing the issue of food security within the confined spaces that community members have access to, we organised a virtual vertical gardening workshop with our community colleagues. We also shared information on an external gardening workshop with them and
provided financial support for two of them to attend the workshop.

The aim was to promote food security by first teaching them the necessary know-how and then having them teach what they learnt to the rest of the team and community members. The team also used the WhatsApp platform to constantly be in contact with the mentors and mentees of the programme, asking them how they were experiencing COVID-19 and regularly checking in with them to assist them to cope. The team members themselves also used their own resources and contacts to navigate their way through the pandemic and its accompanying challenges. One member used his contacts to organise and set up the soup kitchen, which now occurs every week, whereas another member, who works as a home-based carer, used her platform to distribute soup to the elderly who are unable to access the soup kitchens. One member also used her contact with the local mayor to organise and navigate solutions when problems arose within the surrounding areas of the community. These acts of collaboration and the use of existing relationships to strengthen community resilience serve as examples of how continuous community engagement can be a key mitigating factor in addressing multiple challenges during a time of crisis.

CONCLUSION

This paper reflects our experiences and conversations as community activist researchers in implementing creative ways of engagement to address pertinent psychosocial and structural violence issues affecting communities during COVID-19. Concurring with Mashiapata and James (2020), we echo that the pandemic has created opportunities and novel ways of collaborating with multisectoral social actors to address the challenges of the pandemic. In addition to fast-tracking new and innovative means and technologies of engaging with communities, the pandemic encouraged us to reimagine and reconfigure the ways in which we conduct community engagement, research and praxis. This has provided opportunities for a range of accessible online engagements, including training opportunities, regular meetings, capacity development of community structures and dealing with challenges, as well as collaborating and planning multiple strategies to address the immediate needs of our communities.

Even though the pandemic forced us to use digital platforms, we remained reflexively conscious of the digital divide between us as privileged academics and our community colleagues. Every effort was made to bridge this gap by trying to proactively foresee and address challenges through the provision of training, portable modems, and data vouchers in the beginning phases of the lockdown. Future
research will benefit if it reflects multiple voices and perspectives on CE during a pandemic through additional mediums such as the documentation of narratives through song, plays and poetry, and developing CE knowledge bases that are available to both academics and community colleagues (James, 2020). Nonetheless, it is hoped that our reflections will serve as a stepping stone for future CE practices, not only to explore possibilities of CE during times of crisis, but also for a more effective use of digitised engagement. Our conversations and personal experiences as a research team have highlighted the humanising and creative responses to community-engaged research and praxis during the pandemic.

REFERENCES


The Effects of COVID-19 on Women in South Africa: An Analysis using the Social Provisioning Framework

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ABSTRACT
The outbreak of COVID-19 has resulted in the South African government imposing a hard lockdown, bringing the majority of economic activities to a halt. For many countries, this pandemic has worsened existing gender inequalities, although in one of the world’s most unequal countries, these inequalities have become particularly visible. This descriptive study used the five methodological starting points of the social provisioning framework to dissect how this pandemic has affected South African women, a group which has historically been disadvantaged, but has become even more so during the pandemic. The starting points include considering caring and domestic labour, human well-being, human agency, validating ethical judgements, and adopting an intersectional analysis. This paper has drawn together information from various sources which have collected data throughout South Africa’s lockdown to paint a picture of the economic effects which the global pandemic has had on women. It has demonstrated how South Africa’s labour market, social security framework, and issues related to corruption – all of which had been challenges before the lockdown – have exacerbated gender inequality. Though many policy toolkits are available for devising policies aimed at promoting gender equality or at gender mainstreaming existing policies, the social provisioning framework complements the various toolkits by issuing a challenge to adopt a more critical way of thinking about women’s issues within society.

Keywords: Gender equality; women; COVID-19; Well-being; social provisioning framework; reproductive labour

INTRODUCTION

The outbreak of COVID-19 has had devastating consequences around the world. Countries have had to make the difficult choice between allowing citizens to continue earning a living and protecting their
health. As such, many countries introduced some form of ‘lockdown’, where people were encouraged to stay home to avoid the spread of the virus. South Africa imposed its own hard lockdown from 26 March 2020, bringing the majority of economic activity to a halt. Though the lockdown and its associated closures assisted in curbing the spread of the virus and alleviating the initial pressure on an already ailing health sector, the economic consequences have been devastating, with most countries expected to experience a recession in the near future (if they have not already done so) (World Bank, 2020).

Some have claimed that, during an economic recession, men tend to perform worse in relation to labour market outcomes (Alon, Doepke, Olmstead-Rumsey, & Tertilt, 2020; Standing, 2011), although the problem with adopting this view is that it embraces a narrow conception of what is considered valuable within an economy (that being what is considered work) and fails to recognise the challenges which arise when the reproductive and productive spheres intersect with one another; something which is a daily occurrence for many women in society. The evidence of women’s dual responsibilities in the productive and reproductive spheres have been well documented (Connell & Philip, 2007; Cornish, Faraday, & Verma, 2006; McDowell, 1991). Crises which, like the COVID-19 pandemic, affect vulnerable members of society the worst, tend to shed light on the source of such vulnerabilities. This has been evident in what has happened around the world in the last few months. Business and school closures have left these vulnerable groups even more exposed than they usually are – the unemployed, workers in the informal sector, the poor, the youth, and women.

Given prior knowledge on the precarity which vulnerable groups face during times of crisis, and women in particular, it is expected that governments would have leaned towards approaches which are sensitive to these facts. Literature has shown how a case can be made for gender mainstreaming almost every policy which governs our social lives, and that policies which are gender blind tend to put women at a disadvantage, even when this outcome is not intended (Cornish et al., 2006; Council of Europe, 1998).

The case has been made for the need to include gender in every analysis of social policy and how this should be accomplished has been fleshed out with the use of various toolkits and methodology handbooks (Council of Europe, 1998; OECD, 2012; OECD, 2018; UN-Habitat, 2008; UNICEF, 2018). Though these provide useful tools for developing policies which deal with issues arising as a result of gender inequality, or for gender mainstreaming existing policy, during a crisis issues related to gender tend to be a secondary consideration to ‘more pressing’ challenges. In addition, the data required to devise a gendered response to a crisis is often not readily available to adequately utilise toolkits of this
nature. Thus, this paper instead makes use of Marilyn Power’s Social Provisioning Framework (Power, 2004).

The purpose of this framework is to identify an alternative starting point in an economic analysis. In her paper, Power (2004, p. 4) states that “where the analysis begins limits what will be examined and what will be ignored”. The social provisioning framework thus consists of methodological starting points, as Power refers to them and, of these, she outlines five. These include considering caring and domestic labour, human well-being, human agency, validating ethical judgements, and adopting an intersectional analysis.

Power compiled these methodological starting points based on the growing body of feminist economics literature over the last few decades. She does not advocate for a single uniform methodology which must be utilised in undertaking studies in the field, but bases this framework on her observation that “a study of the growing body of feminist economic literature suggests a coalescence around certain basic principles as points of analytic departure” (Power, 2004, p. 4). Indeed, a review of the feminist economics, and to some extent the feminist literature in general (though too many to mention here), reveals that these methodological starting points are a general feature, albeit that many studies evaluate only one or two of these starting points at a time (Casale & Posel, 2010; Crenshaw, 1989; Duffy, 2007; Floro & Pichetpongsa, 2010; Hancock, 2007; Klasen, 2004; McCall, 2005; McNay, 2016; Nelson, 2010; Peter, 2003; Rakovski & Price-Glynn, 2010).

The strength of the social provisioning framework lies in the fact that it provides a comprehensive look at an event and also provides an opportunity to sketch a bigger picture of circumstances, even if at just a conceptual or theoretical level – a feature which is missing from the studies cited in the previous paragraph. Though an in-depth analysis of all of Power’s starting points in a single study is not desirable, the social provisioning framework explicitly draws out and anchors the (often implicit) assumptions of other authors within a broader feminist structure. Having a bigger picture as a starting point inevitably influences how application of the finer details will take place. It also allows for an overview of how every policy or action has a gendered effect and moves away from viewing gender equality as an ‘add-on’ once other social issues have been accounted for.

Though Power does not present this framework as rigid or absolute, she encourages the use of these points simultaneously, as far as possible, when analysing events or policies which affect women. She has also developed this framework based on a consideration of aspects which feminist scholars have
traditionally included in their work, and such a framework could prove useful beyond just interrogating gender differences. It could also, however, be applied to class, race, and other differences which create structural disadvantages in our society.

This descriptive study used the five methodological starting points of the social provisioning framework to dissect how this pandemic has affected South African women, a group which has historically been disadvantaged in society, but has become even more so during this global pandemic. This paper thus draws together information from various sources which have collected data throughout the lockdown to draw a picture of the effect which the global pandemic has had on women, young and old, economically active or not. Important to note, however, is that the goal here is not to discuss each element of the social provisioning framework in-depth, but rather to demonstrate how each of these elements allow us to flesh out the gendered experiences women face in a time of crisis, as well as during any other ‘normal’ time in our society. This paper will highlight how traditional vulnerabilities of women have been exacerbated during the COVID-19 global pandemic in South Africa, emphasising the need to consider gender in all policy deliberations, but also to take a broader view of challenges when undertaking an economic analysis.

This paper will start with a description of the five methodological starting points, followed by a discussion of how each of these starting points is sufficiently relevant to consider in the current economic climate. This will be followed by a short discussion and finally some recommendations in a concluding section.

**POWER’S SOCIAL PROVISIONING FRAMEWORK**

Power’s (2004) Social Provisioning Framework challenges the traditional way in which economic analyses of social problems and policies starts and, she argues, ultimately ends. As such, she proposes a broader framework with which privilege or disadvantage within an economic system can be examined. In her 2004 paper, she argues that “caring labor and domestic labor are vital parts of any economic system and should be incorporated into the analysis from the beginning, not shoehorned in as an afterthought. One implication of this view is that interdependent and interconnected human actors are at the center of this analysis rather than the isolated individual” (Power, 2004, p. 4). Here, she refers to the first element within her methodological framework which relates to caring and domestic labour.
In her text, she emphasises the need to undertake household analyses as well as individual analyses. The former are able to capture the dynamics between broader society and the household, as this is traditionally considered the domain of women (the private or reproductive sphere), while individual analysis (similar to including only analyses at the household level), excludes intrahousehold power dynamics. This is emphasised by Himmelweit and Mohun (1977, p. 16) who state that housework “plays an important reproductive role with respect to ideology. For the family has a crucial stabilising function through the allocation of socially defined roles, both in the conditioning of children and in the maintenance of [a] docile, disciplined [and] divided working class. The family is one of the most important units for the socialisation of individuals in capitalist society”. They further state that “[a]uthoritarian relationships in social production (capitalist to worker) are facilitated through their previous observation and acceptance in the home (parents to children and husband to wife)” (Himmelweit & Mohun, 1977, p. 16). Similar sentiments have been shared in the more-recently drafted white paper on families (Department of Social Development, 2013). This labour which women primarily perform is thus not just in service of the family with which they reside, but plays a crucial role in maintaining a social order within society.

The second element in the social provisioning framework relates to human well-being. In the framework, human well-being requires a move away from traditional economic measures of well-being, wealth and income. The concept of human well-being is also closely related to human agency and ethical judgements. In her discussion on human well-being, Power draws closely on the work of Amartya Sen who developed the capability approach, which focuses more on “what people are able to be and do, and not on what they can consume, or on their incomes” (Robeyns, 2003, p. 62). Sen’s approach goes beyond income measures to identify the types of political freedoms which people enjoy and the types of institutions within society which enhance or hinder individual freedoms (Sen, 1999). A lack of such freedoms and institutions can sometimes limit personal freedoms regardless of the wealth an individual enjoys. Sen’s framework has been criticised for its lack of commitment to defining what well-being means, although this has also been identified as a strength of Sen’s work, given the subjective nature of well-being (Hill, 2003). Well-being will be defined differently, depending on the time and place in which individuals find themselves. However, accommodating every single individual is not possible, and nor is it practical in the realm of public policy decision making. Many authors (too many to mention here) have thus measured well-being using a set of pre-defined factors which are

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2 Though power does not explicitly make the distinction between paid and unpaid reproductive labour, the distinction will be made in this paper.
objectively measurable (Bhorat & Kanbur, 2005; Bookwalter & Dalenberg, 2004; Villamagna & Giesecke, 2014; White, 2010).

Sen’s measures of well-being relate to the freedoms of individuals, which are characterised by *choices*.

Someone may not have the desire to exercise a freedom at a particular point in time, but it is important that they have the choice to decide not to. In his analysis, he refers to five instrumental freedoms which attempt to list aspects which define an individual’s relationship to their communities or the state. These include political freedoms, economic facilities, social opportunities, transparency guarantees and protective security (Sen, 1999). While these instrumental freedoms do not define well-being as subjectively as a scale which attempts to measure individual life satisfaction, the point that this paper argues and attempts to demonstrate is that living conditions within the public sphere are intimately connected to conditions within the private sphere (household) and by extension, the individual. The advantage of using Sen’s instrumental freedoms is that they represent the extent to which individuals have choices. Sen thus views a restriction on the choices people have as a limitation on their well-being.

Political freedoms, he defines as the right to choose who may govern a society as well as working accountability mechanisms once the chosen parties are in power, while he defines economic facilities as the resources which one has access to which enables production and consumption. Social opportunities refer to access to services such as education and healthcare which will have a direct bearing on one’s ability to uphold a decent quality of living, and transparency guarantees, the factors which influence trust within a community. Corruption is an example of a factor which has a bearing on this last-mentioned freedom. Finally, protective security simply refers to the safety net which individuals are able to access to prevent any undue suffering. Sen (1999) specifically mentions the need for all of these to work in conjunction to enhance the freedoms of individuals within a society.

Closely related to the human well-being aspect is that of human agency. The more freedoms individuals are guaranteed in society, the more their human agency will be enhanced. Agency has been defined as “the capacity of a person (or other living and material entities) to intervene in the world in a manner that is deemed, according to some criterion or another, to be independent or relatively autonomous” (McNay, 2016, p. 40). Power (2004) thus emphasises the need to focus on *processes* and not just *outcomes*, and by doing so to consider the distribution of power in a particular process and how that could lead to a particular outcome.
One of the assumptions of mainstream economics theory is that arguments should be based on positive statements, i.e. that an economic analysis should be value and judgement free. However, Power (2004, p. 5) argues that “ethical judgments are a valid, inescapable, and in fact desirable part of an economic analysis”. Other feminist scholars have also argued that the pursuit of a positive rather than a normative approach to designing interventions does not leave policies and theories value free, but only serves to mask “implicit assumptions about race, class and gender” even if done so unintentionally (Barker, 1999, p. 572). It is thus important to engage with value judgements so as to make clear what implicit assumptions underlie public policy decision making.

Lastly, Power’s framework advocates for the adoption of intersectional analyses. This allows for the consideration of the multiple identities which women carry beyond just their gender. The most common of these include race, class, and sexual orientation. Given that this requires an additional layer of analysis which should complement the first four points, this will not be presented as a separate section in the discussion which follows, but as a complementary layer to the other elements. The following section applies the social provisioning framework to the situation women have found themselves in during the COVID-19 pandemic.

THE METHODOLOGICAL STARTING POINTS IN SOUTH AFRICA’S COVID-19 RESPONSE

This section will consider how the global pandemic and the consequent response from the South African government has affected women – using the methodological starting points provided in the social provisioning framework.

CARING AND DOMESTIC LABOUR

The global pandemic has had devastating economic consequences and has resulted in job losses and business closures. This problem has been particularly acute in the South African economy where unemployment was a pre-existing challenge. Since 1994, the unemployment rate has remained stubbornly above 20%, increasing to an all-time high of 30.1% in the first quarter of 2020 (Stats SA, 2020b). The stoppage of most economic activity exacerbated this problem and it has been estimated that there was a 40% decline in employment amongst working-age individuals (Jain, Budlender,
Zizzamia, & Bassier, 2020). These losses disproportionately affected women and the occupations in which they tend to be employed, as it is also estimated that two-thirds of all job losses which occurred between February and April (the first month of the lockdown) were lost by women (Casale & Posel, 2020; Jain et al., 2020). Stats SA (2020a) had further reported an unemployment rate of 32.3% for women (compared to 29.6% for men) in the third quarter of the year, indicating how the hard lockdown had exacerbated poor labour market conditions.

Though these figures only emphasise the extent to which losses were evident in wage work, they do show how economic deprivation has been gendered and how part of this is as a result of the burden which households tend to carry during such difficult times. Households act as an insurance mechanism for working individuals in many countries, particularly for those who live in poor households and have limited access to unemployment benefits (Bhalotra & Umaña-Aponte, 2010; Klasen & Pieters, 2012).

In South Africa, the role which households play and have historically played is well institutionalised. During the apartheid era, the Reserves (or homelands) housed the bulk of unpaid reproductive labourers and this assisted in keeping the economy running and the apartheid regime profitable for many years. Here, women took care of children and the elderly, as well as the sick when they returned home from the mines – ill or injured (Bozzoli, 1983). These women served as the social security net which the government did not provide to the population of colour – black women bearing the greatest brunt in this regard (Dinkelman & Pirouz, 2002; Pillay, 1985). The domestic role which women played during this time is still acutely relevant today. Though the democratic government has provided for a more equitable social security net, this does not include people who are able-bodied and of working age – thus excluding a large part of the population (Mackett, 2020). As such, many women still act as a source of social security where the government’s net falls short. This is evident in how household formation has evolved around recipients of government grants; old-age pensions in particular (Klasen & Woolard, 2009).

The economic impact of the global pandemic has thus impacted women’s domestic and caring roles in two respects. The first of these is as a result of the closure of restaurants and fast-food outlets, the

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3 These data are based on the NIDS-CRAM survey which was, in turn, based on a sample of 7 074 interviews, representative of the 2017 nationally representative NIDS sample. These data are thus not representative of the entire South African population, but rather of the 2017 NIDS sample, which is a sub-sample of the South African population (Kerr, Ardington, & Burger, 2020). In addition, some of these individuals who reported being out of work were temporarily out of work while others had become unemployed.
closure of schools and early childhood development centres, and the return of domestic workers and child minders to their primary residences. This has meant that women, who tend to perform the bulk of unpaid reproductive labour within the home (Rubiano-Matulevich & Viollaz, 2019), have experienced an increase in their domestic responsibilities, as 77.9% of wage workers reported working from home as a result of the national lockdown (Stats SA, 2020c). The majority of these had previously worked in non-residential buildings, prior to the lockdown. Evidence shows that far more women than men reported increased time spent on childcare as a result of the closure of educational facilities (Casale & Posel, 2020); similar evidence was also forthcoming in developed nations (Andrew et al., 2020). This would have been particularly severe for women given that children are more likely to be co-resident with their mothers or another female family member in South Africa (Posel & Grapsa, 2017). These matters highlight the challenges in relation to unpaid reproductive labour. With regard to paid reproductive or caring labour, women suffered similar vulnerabilities. According to the latest labour force survey data, women made up 55.39% of health professionals and 74.89% of health associate professionals (see Table 1). For these women, caring responsibilities extended beyond the households in which they live.

Though cashiers, tellers, and related clerks are not necessarily reproductive workers, they (together with the health professionals referred to) were classified as essential service workers since the beginning of the hard lockdown (Department of Health, 2020). Women made up 81.49% of these service workers, and black women 82.68% of the female workers who were employed in this occupation group (also in Table 1). These women would have had to manage their paid work outside of the home, as well as unpaid work within the home, during the lockdown period.4

<table>
<thead>
<tr>
<th>Table 1: Female-dominated essential services occupations by gender (%)</th>
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<tbody>
<tr>
<td>Health Professionals</td>
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<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
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</table>

4 If living in a single-parent household, many of these women would also have the added worry of possibly leaving their children unsupervised during the day when they go to work should no other adult or household be available to assist in this regard.
Though these are some of the worst-affected women in the economy in relation to the work burden they experienced, there are many women who continued working from home, having to find a similar balance between their paid work and their domestic duties. The burden of unpaid reproductive labour (and paid reproductive labour for some) has thus been a key extenuating factor for women during the lockdown and this has resulted in additional vulnerabilities for women, which will be highlighted in the following sections.

HUMAN WELL-BEING AND AGENCY

Human well-being is broadly defined, although here it is discussed in the context of the five instrumental freedoms proposed by Sen (1999). In addition, given that access to these freedoms, or a lack of such access, has a direct bearing on human agency, human well-being and agency are discussed in tandem here.

At all levels of education, and within each earnings percentile, women were more likely to lose their jobs than men (Casale & Posel, 2020). The resultant job losses had severe consequences for women’s economic facilities, specifically those who live in grant-receiving households (Van der Berg, Zuze, & Bridgman, 2020). Many of the grant-receiving households tended to rely on other forms of income in addition to the grant income, and most recipients tended to be women – specifically Child Support Grant recipients (Köhler & Bhorat, 2020; Wills, Patel, van der Berg, & Mpeta, 2020). Furthermore, where the Old-Age Pension was received, research has shown that female recipients displayed spending patterns which were more beneficial to the well-being of the entire household, as opposed to their individual needs (Duflo, 2000). The loss of employment and subsequent income would thus have had consequences which reached beyond the newly unemployed, but also their families, specifically if the person who lost their job was a woman.
The loss of employment, which disproportionately affected women, thus impacted women’s economic facilities, but also their social opportunities. Women have experienced hardship due to the closure of educational institutions, but also as a result of the health-related nature of the crisis. The closure of educational institutions also has the potential to affect the ability of girls to return to school in the long-term, given the increased risk of sexual abuse within the household, as well as domestic violence, as schools no longer serve as a place of shelter for the bulk of the day. Furthermore, given that women and girls bear the brunt of reproductive labour in the household, it is expected that, during a health crisis, many of them would be required to assist in the household when members of that household fall ill. Thus, even when schools do open, the domestic burden which girls and women carry present a risk factor to their continuing education. This would have longer-term implications for the empowerment of women.

In the aftermath of the Ebola crisis in West Africa, girls were less likely to return to school as a result of an increase in the incidence of teenage pregnancy. This stemmed from the fact that many children had been left “unsupervised and more visible” to sexual predators (Menzel, 2019, p. 444) and, in some countries, girls were forced to provide sexual favours in return for food (Elston, Cartwright, Ndumbi, & Wright, 2017). An additional challenge experienced during that time was that in some instances children had started working for a wage to help support their households and this created a disincentive for parents to invest in further education (Elston et al., 2017).

In terms of transparency guarantees, South Africa’s endemic corruption problem has also reared its head during this pandemic. Reports of the mismanagement of funds intended to provide relief during the lockdown to the vulnerable population have been noted (Makwetu, 2020), and while these have been devastating to the poor, in general, it is important to note the differential affect which corruption has on women.

An important gap in the literature relates to the fact that most tools traditionally used to measure corruption do not take gender into account (Hossain, Musembi, & Hughes, 2010). Given that women make up a disproportionate share of the vulnerable population, the lack of access to public services, which is often a result of corruption, affect them the worst. Thus, if money which is meant to help the poor is stolen, women are worst affected given that they make up the majority of the poor, but also

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disproportionately make up the households in which there would have already been a lack of basic services (Casale & Desmond, 2007; Hall & Sambu, 2018). If these services are not readily available in the household, it would again be the women and the girls who make up for this through their domestic responsibilities, where they would spend a greater proportion of their time compared to men fetching water, firewood and other necessities for the functioning of the household (Antonopoulos, 2009; Carter & May, 1999).

The erosion of trust in public institutions not only relates to the explicit abuse of resources in which many public officials engage, but also includes citizens’ perception of the competence of public officials and their ability to make use of public services to achieve just outcomes. One example of this is the perception that citizens hold of the police service and the impact that this has had on gender-based violence.

The rate of gender-based violence has increased during this lockdown period, owing to the closure of havens where women (and girls) would normally find safety when such incidents occur, but also as a result the lack of capacity in the police service to prevent and/or remedy such incidences (Carrington, Guala, Puyol, & Sozzo, 2020). It has been found that women tend to avoid reporting incidents of abuse due to the risk of secondary victimisation and lack of trust in the police, amongst others (Keller, 2017).

The instances of corruption and inability of the police service to adequately respond to issues related to gender-based violence also impact the political freedoms of women, which include the ability to make use of accountability mechanisms. However, Hossain et al. (2010) have indicated that many public sector accountability mechanisms are gender blind and do not include the promotion of gender equality as a core outcome.

Lastly, a lack of protective security also has more devastating effects on women. The structural constraints left by the apartheid regime and the current design of South Africa’s social security system leave households with the responsibility of providing this security net to a vast number of unemployed individuals. Theories such as the added-worker effect state that women often enter the labour market when the main breadwinner (often male) loses their jobs (Fernandes & De Felicio, 2005; Spletzer, 1997). While this presents a problem, given that such workers would tend to accept precarious work

in desperation, a larger challenge arises when a woman is the only working adult within the household.

The increase in female-headed households, due to the loss of the main breadwinner as a result of HIV-related deaths and increasing divorce rates, has been cited as one of the reasons for the feminisation of the labour force over the last two decades, and the placement of many of these women in low-paying, insecure jobs (Casale, 2003; Ntuli, 2007). This has had adverse effects on women’s agency and their precarious positions in both the productive and reproductive spheres will negatively affect their well-being and agency. This well-being is implicitly related to the value judgements underlying the policy frameworks in South Africa, particularly those related to social protections of individuals.

VALIDATING ETHICAL JUDGEMENTS

South Africa’s macroeconomic framework makes the implicit assumption that working for a wage is to be equated with success. This is evident in the social security framework which the country has adopted, as well as the revenue model on which it relies.

As discussed earlier, South Africa’s social security framework does not make provision for individuals who are able-bodied and of working-age – with the exception of the Unemployment Insurance Fund (UIF) (Mackett, 2020). In terms of its response to the COVID-19 crisis, a grant (the Social Relief of Distress (SRD) grant) was made available to unemployed individuals who did not receive any other grant or qualify for UIF benefits (South African Government, 2020). Those who did receive existing grants were given an additional amount each month, although this benefit ended on 30 October 2020. The conditions under which the unemployed could apply for this grant were thus stringent, but still emphasised the need to work. The R350 SRD grant was aimed at the unemployed who did not receive any income or other grant, and recipients needed to be permanent residents in South Africa, South African citizens, or registered refugees (in addition to other qualifying criteria).

The stringent conditions under which the SRD grant has been made available excluded many vulnerable

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7 The Unemployment Insurance Fund (UIF) is a contributory fund which workers and their employers contribute to and which can be accessed in case of a temporary absence from work (e.g. maternity leave) or a longer absence related to unemployment. Only those who have been previously employed and whose employers have registered them for this benefit can thus access it. In the informal economy, many workers will thus not benefit from the UIF.

8 These were available to individuals over the age of 18, who were unemployed, did not receive any other grant, did not qualify for UIF, and did not receive any other income (South African Government, 2020).
individuals, such as those who may already be receiving existing grants, but who may still be living in poverty, those who may not have access to banking services, as well as those who receive remittances from family members, but who remain in impoverished households. In addition, the citizenship requirement for the SRD grant raised important issues in relation to rights and who is entitled to have those rights (Turner, 2001). According to Stats SA (2020d), migrants were more likely to be unemployed and living in an informal dwelling and, if they were employed, more likely to be employed in the informal sector.

Despite some of the shortcomings of this relief programme, organisations and scholars have called for the permanent instatement of the SRD or a similar grant,\(^9\) as well as a continuation of top-up amounts to existing grant beneficiaries, although the termination of this benefit has continued.\(^10\) Appeals have also been made to consider increasing the grant amount so as to push recipients above the food poverty line.\(^11\)

Coupled with job losses, South Africa’s social security landscape has been characterised by temporary relief measures in areas where more permanent solutions are needed. This is also evident in the country’s revenue model which relies heavily on personal income tax. In the 2018/19 fiscal year, tax revenue constituted 26.2% of government revenue, and personal income tax made up close to 40% of this revenue base (National Treasury, 2020). This paints a picture of a revenue model which relies heavily on a non-functioning labour market, and in which women are in a generally disadvantaged position.

Adding to this, many of the country’s service delivery mechanisms have failed to provide quality services, or any services at all (Alexander, 2010; Managa, 2012; Nleya, 2011). This has resulted in a large proportion of formally employed individuals who make use of private services, such as healthcare, security, and education (Ahmed & Sayed, 2009; Benatar, 2013; Fedderke, Kadt, & Luiz, 2000;)


The ‘voluntary’ privatisation of many publicly provided services is testament to the failure of government to provide adequate services.\(^{12}\)

The ability to access privately procured services, as well as the conditions on which the social security protection is provided, values labour in the productive sphere. This does not consider responsibilities in the reproductive sphere which may impede the ability of working-age individuals to fully engage in it. An additional layer to this problem includes the fact that the labour market has failed to provide an adequate amount of jobs for those who are willing and able to spend some of their time in the productive sphere, hence the high unemployment rate. However, even without considering the latter point, women would again be disproportionately affected by the value judgements related to wage work.

For many, their reproductive labour responsibilities have impeded their ability to engage fully in wage labour, and this capacity would have been even more reduced during the lockdown. This has already been noted in the job losses which women have suffered as a result of their domestic responsibilities. The push towards wage labour as an aspirational goal is thus an implicit value judgement in the South African policy framework and fails to acknowledge and accommodate the limitations which would accompany such assumptions. The current crisis has served to expose these existing shortcomings and exacerbate them and the next section will demonstrate how these factors have coalesced to deepen women’s vulnerability within South African society as a result of the global pandemic.

**DISCUSSION**

A key theme which arises from the high-level analysis is that women’s hardship is not just a result of recent developments which have accompanied this crisis, but primarily as a result of structural barriers which they faced even prior to the onslaught of the health crisis and the accompanying lockdown. These include disadvantages in the labour market, the healthcare sector, along with the lack of public service delivery and ongoing corruption at the hands of public officials. Not only were women more likely to be exposed to the risks the virus poses as a result of the feminised nature of some essential services occupations, but they have also been disproportionately affected by the job losses which occurred as a result of the health crisis.

\(^{12}\) This disparity is also evident in the South African healthcare system where delays in COVID-19 test results were an issue in the public healthcare sector, but not necessarily in the private sector. This was reported by Amy Green in Spotlight on 24 June 2020, ‘COVID-19: Stark differences between public and private sector testing’, https://www.spotlightnsp.co.za/2020/06/24/covid-19-stark-differences-between-public-and-private-sector-testing/.
result of the hard lockdown being imposed. Those who were able to maintain their employment had to cope with their paid work as well as the increased domestic burden due to the closure of educational institutions and other service providers which would normally serve as mechanisms to ‘outsource’ household responsibilities – such as cooking and cleaning. As such, women’s working time (on both paid and unpaid labour) has increased significantly, putting them at greater risk of burnout and mental distress.

The effectiveness of South Africa’s social security framework was also called into question, given the value judgement which it implicitly makes about the importance of wage work. An additional layer of this judgement is women’s precarious position in the labour market owing to their over-representation in paid reproductive work, as well as their socialised responsibility for unpaid reproductive work in the household. The weaknesses in both the social security framework as well as in the South African labour market, both existent long before the current crisis, have thus been exacerbated, leaving women in an even more vulnerable position than they were before. A value judgment which is warranted here is that expecting individuals to seek survival from a non-functioning labour market is unjust and an infringement on many Constitutionally guaranteed rights. The broad literature on the failing South African labour market fails to address the core issue which relates to the need to work. Additional criteria related to the social grants also serve to exclude vulnerable groups in the country, such as demonstrating extreme vulnerability, but having the resources with which to receive the grant.

The gendered effects and implications of corruption were also touched on, and it was noted how a lack of services is likely to affect women more adversely than it does men – this mainly as a result of their responsibility for the unpaid reproductive labour which would be required to make up for the lack of services. This creates an additional burden for women, who then not only suffer from money poverty but also time poverty (Musingarabwi, 2014; Posel & Grapsa, 2017; Rubiano-Matulevich & Viollaz, 2019). Corruption is also instrumental in explaining the underreporting of incidences of GBV amongst women, given their lack of trust in the police. Corruption thus affects women not only to the extent that it results in a lack of service delivery – services which are needed to free up women’s time for more ‘productive’ activities – but also to the extent to which they are able to make use of public resources to enhance their physical security and seek justice when their rights are infringed upon. Though the years immediately preceding the outbreak of COVID-19 have been marred by incidents of femicide (Naeemah, Mathews, Jewkes, Martin, & Lombard, 2012; Stats SA, 2018), the pandemic has illuminated the extent to which women are not only vulnerable to threats outside their homes, but more importantly to threats inside their homes too. Conditions outside the home are thus intricately linked to what happens
inside it and the extent to which women can seek recourse in the public sphere to issues which are considered ‘domestic’.

A positive development of this difficult phase has been the ability to reflect on what works and what does not in our society. These have already been made clear in the discussions which have arisen, particularly those related to the basic income grant. However, a few other considerations are listed in the following section.

PREVENTION IMPLICATIONS AND CONCLUSIONS

The novel coronavirus has had wide reaching social implications for society, affecting the most vulnerable in our society most severely. This paper has made use of a more holistic approach through employment of the social provisioning framework developed by Marilyn Power. She recommends that caring and domestic labour, human well-being, human agency, validating ethical judgements, and undertaking intersectional analyses be considered. This paper has introduced and briefly defined each of these methodological starting points and then applied them to what has come out of the current crisis and the government’s response to the crisis.

A limitation of this paper, however, is that each of the methodological starting points need in-depth study, and that a deeper discussion of the pandemic in relation to each of them will require separate studies and varying methodologies. Despite this, the paper has demonstrated the usefulness of this framework to undertake a gendered analysis of a particular event or policy. As such, this paper has also demonstrated how women have been adversely affected by the current COVID-19 pandemic.

An additional limitation of this paper is that data to fully comprehend the impact of the current pandemic is not readily available, though this is expected given that the crisis is ongoing. The analysis does attempt to mitigate this by briefly touching on some of the longer-term effects which have resulted from the Ebola crisis in West Africa. These include the increase in teenage pregnancy and the longer-term effects on the educational advancement and mental well-being of children who stayed away from school during the lockdown period.

With the use of the social provisioning framework, along with existing literature and reports, this paper has demonstrated how almost every negative aspect which accompanied the current global pandemic had graver consequences for women than for men. As such, it makes a case for the ongoing calls for gender mainstreaming of old policies and new policies, as well as long and short-term interventions. The greatest strength of Power’s methodological starting points is that she provides a structured way in which to undertake such an exercise.

The first policy implication which could be considered is the government’s philosophy behind its social security and labour market policies. Rather than consider how equality can be enhanced in the labour market – which is in itself a necessary goal – the discussion should move towards how individuals can obtain social protection (and quality services) without necessarily having to engage in labour market activity. This is important given that unemployment has been a persistent problem in South Africa, but also given the changing labour market conditions which entail an informalisation of labour markets more generally, and the introduction of automation into production processes (Barchiesi, 2010; Hirschi, 2018). These are likely to affect the longer-term labour market prospects of a large part of the population, many of whom make up the youth, and young women in particular. The discussion needs to shift to a new politics of redistribution to ensure that the labour market is not the only tool through which people can attain and maintain a decent standard of living (Ferguson, 2015).

Related to this point is the issue of service delivery. The privatisation of public goods within South Africa is testament to the government’s inability to provide quality services to its citizens and these basic human rights – which are entrenched and protected by the South African Constitution – should not be linked to privileged access to good quality employment in the labour market. The lack of capacity of the South African government to provide quality services is linked to issues of corruption and wasteful spending and usage of resources. The literature cited in this paper has also provided evidence of how corruption disproportionately affects women.

The positive effects of being led by a woman during the pandemic has been documented and studies have also show that having a greater proportion of women in leadership positions could have important implications for a reduction in corruption (Garikipati & Kambhampati, 2020; Hossain et al., 2010). It is thus necessary to find mechanisms which can ensure greater representation of women in higher office, but this representation is also affected at the provincial and local government levels where implementation could become an issue.
To contribute to the eradication of GBV, the Labour Research Service has provided solutions in order to suitably respond to incidents of GBV, as well as to prevent it. These include ratifying the ILO’s global standard to end violence and harassment in the world of work, as part of addressing unequal power relations as a root cause of GBV (Solidarity Center, 2019), funding civil society organisations which promote women’s participation in the public sphere, providing more widespread clinical services which are specifically designed to deal with GBV, and disrupting the cycle of GBV by being more attentive to the needs of children who are survivors of GBV.¹⁴ Many of these points have been reiterated by other civil society organisations, in addition to investing in community protection and providing legal protection and assistance to women who are vulnerable (Oxfam, 2020).

Lastly, the human well-being and human agency elements of the social provisioning framework emphasise the need to consider not only material well-being, but also mental well-being. Thus, going forward, qualitative evaluations of women’s mental well-being (and the mental well-being of members of society in general) during this time of crisis is necessary. Many may have experienced emotional and mental hardship, specifically in the light of the social distancing policies which were introduced and the trauma which arose as a result, with the increased incidence of gender-based violence being a key contributing factor to this trauma.

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Exposing Inequity in Australian Society: Are we all in it Together?

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ABSTRACT

The COVID-19 pandemic does not discriminate, and the Australian government has sought to embrace a sense of universality, adopting the slogan ‘we are all in it together’. However, the pandemic has also exposed layers of systemic, structural and cultural inequities, challenging this notion of a common good. The authors, based in Victoria in Australia, have experienced two periods of lockdown, observing the tensions between individualist, libertarian tendencies and civil society perspectives within the context of Australian multiculturalism and latent colonialism. In this paper, the authors discuss the ways in which whiteness and colonialism are embedded in the government’s public health and social policies whilst being subject to emergent contested spaces. Drawing on media reporting between January and August 2020, the authors analyse the intransigence of white, often xenophobic, privilege and the disruptive, countervailing forces, from the Black Lives Matter movement to localised acts of community solidarity. The COVID-19 virus has exposed layers of social inequity and their entrenched everyday structural and cultural violence in Australia and, in so doing, has provided both opportunities and challenges to people who are striving for social justice and the notion of the common good.

Keywords: Pandemic; inequity; racism; migrants; international students

INTRODUCTION

As the COVID-19 virus emerged as a global pandemic, ‘we are all in it together ’became a popular call for solidarity in Australia, first brought to prominence at a press conference on March 27 by Prime Minister Scott Morrison (Prime Minister of Australia, 2020a, para. 1). In epidemiological terms, the tiny virus does not discriminate, and this statement embraces similar inclusivity. However, the civil
society ethos of this slogan has also been exposed as utopian, at best, or a form of mythmaking, as the impacts of the pandemic expose layers of socio-political and economic inequities. In this paper, we focus on the concept of equity which refers to just and fair implementation of public policy and distribution of public services, and the ways of responding to an event and perceived fairness of the event (Frederickson, 2010). In particular, the paper explores the ways inequality links with race and racism.

As Arundhati Roy eloquently wrote, “the tragedy is immediate, real, epic and unfolding before our eyes. But it isn't new. It is the wreckage of a train that has been careening down the track for years” (Roy, 2020, para. 8). Indeed, the pandemic has exposed multilayers and multiplicities of systemic, structural and cultural inequities, challenging the notion of a common good. The impacts of the pandemic are significantly different from individual to individual, depending on one's socio-economic background, age, gender, race, geographical location, marital status, employment status, visa status, and the list could go on.

We are in the midst of a second wave of infection and 'Stage 4' lockdown in Melbourne, Australia as we write this article. Our analysis is therefore time and space sensitive and is imbued with reflections and observations on various tensions and inequities unfolding around us. The tensions transcend the intrapersonal, interpersonal, family and community, spanning local, national and international domains. The issues relating to inequities cut across races, gender, age and socio-economy. They criss-cross political ideologies, different worldviews and versions of histories. These entanglements are not limited to individualist, libertarian tendencies and civil society perspectives, having disrupted left-right paradigms on many levels. They extend into the context of Australian multiculturism and coloniality and the patterns of Othering migrants and people of colour across the Australian political spectrum.

The magnitude of the pandemic's disruptions at every level is profound. This paper focuses on the ways in which the Australian government and mainstream media have responded to COVID-19 and its effects on international students and migrants in Australia. In particular, we focus on the notions of whiteness and coloniality in our analysis.
WHITENESS AND COLONIALITY

Whiteness is associated with the history of slavery and colonialism, “devised to create a deliberate hierarchy, to define who was privileged and who was property or a second-class citizen” (Williams, 2020, p. 3). Class and race are part of the dominant narratives of colonialism and are reflected in various public health and social policies in Australia. Historically, the White Australia policy, emerging in the wake of the dispossession of indigenous nations in 1788 and exclusion of non-European migrants, defined Australian coloniality until official policies of multiculturalism were proclaimed in the 1970s, particularly with the passing of the Racial Discrimination Act in 1975. The legal, political and cultural mechanisms of the White Australia policy were tied to a widespread belief in the superiority of British civilisation and the white race generally during this era (Jones, 2017).

Australia in 2020 is a prosperous nation with an increasingly multicultural society, within an entrenched system of white privilege that is both structural and cultural. According to 2016 census data, one in four of Australia’s 22 million people were born overseas and nearly half of the Australian population have at least one parent who was born overseas (Australian Bureau of Statistics, 2016b). The government, or more specifically, the Australian parliament, is strikingly homogenous and white. As of 2018, fewer than 20 of the 226 federal parliamentarians have a non-English speaking background (Tasevski, 2018).

Whiteness in senior leadership prevails in numerous prominent sectors and industries, including Australia’s media and broadcasting (Rogers, 2020) and the higher education sectors (Croucher, Wen, Coates, & Goedegebuure, 2019). The lack of diversity in the media sector is increasingly being called out, along with the lack of representation which stimulates systemic bias (Roddell, 2020). It has been notable that, whilst the federal and state public health responses to COVID-19 in Australia have been lauded domestically and internationally as an effective containment model, there has been scant recognition of Asian expertise in public health management in Australia’s mainstream media coverage, creating conditions for stigmatisation and discrimination around issues such as mask-wearing and China’s role in the pandemic.

As borders close and economies increasingly emphasise domestic characteristics, national and provincial identities are being reinforced leading to the re-assertion of Australian nationalism, invoking models of coloniality. The affirmation of whiteness in the construction of Australian identity has been
commonplace in Australia’s mainstream media, as evident in the recent report, *Who Gets to Tell Australian Stories?* (Arvanitakis et al., 2020). In detailing systemic cultural bias throughout the media landscape, the report provides insights into the weaknesses facing public health communication in Victoria.

At first glance, the statement by the Victorian Chief Health Officer, Brett Sutton, referring to the risks associated with drawing on “social media from their country of origin or amongst their network of friends as their primary source” of information is primarily concerned with addressing problems of public health misinformation (Davey & Boseley, 2020, para. 2). The chicken-and-egg problem of the lack of diverse representation in audiences alongside the lack of diversity in Australia’s media production have been exposed by the failures of national public health communication with migrant communities. However, this statement also reveals the lack of awareness of the realities of diasporic modes of communication, manifested in intra-community information sharing and the emergence of multilingual, international digital media networks.

The systemic policy failures in public health responses in migrant communities also have parallels in the political and media discourse around the scope and value of diasporic knowledge. This has been most noticeable in regard to the use of face masks for protection against the transmission of COVID-19. The face mask, now a symbol of libertarian and conspiratorial debate in many western countries, was initially defined by a racialised response in Australia with mask-wearing prominent within Asian communities, consistent with common pandemic health responses in other countries.

In the early months of the pandemic, Australian government officials often questioned the efficacy of face masks. This coincided with a period of systemic and episodic discrimination against Asians in Australia, prompting some community organisations to advise against wearing masks. This implied an insular, parochial approach to pandemic control, effectively negating or discrediting Asian knowledge and expertise. Furthermore, when the Victorian state government implemented laws enforcing the wearing of face masks from July, this occurred without public self-correction, despite media articles having appeared commenting that “Asia may have been right all along” after “weeks of public health authorities, politicians and media figures confidently claiming masks do not help” (Griffith, 2020, para. 4).
MIGRANTS AND INTERNATIONAL STUDENTS UNDER COVID-19 IN AUSTRALIA

The impact of both systemic and episodic white privilege on migrants and international students can be traced back to the early stages of the virus outbreak. The first crack in the notion of being “all in it together” emerged with the March 30 announcement of the JobKeeper government assistance package complemented by unemployment and other welfare programmes (Prime Minister of Australia, 2020b). The JobKeeper and JobSeeker programmes, representing the primary government financial assistance measures, were broadly supported and embraced across Australia (Hamilton, Preston, & Edmond, 2020), despite excluding temporary visa workers and international students.

More than half a million international students and hundreds and thousands of people on temporary visas in Australia faced financial hardship and potential deportation within days and weeks (Martin, 2020). The education sector in Australia was the third largest exporter, amounting to a $38 billion dollars industry (Babones, 2019; Hurley, 2020), with China being the largest source of international students in Australia. Students from other non-western countries, such as India, Malaysia, Nepal and Brazil constitute the top sources of revenue through higher education (Department of Foreign Affairs and Trade, 2019).

In comparison with other countries, Australia has the highest number of international students per capita. Indeed, international students made up a significant population in many Australian suburbs, such as 44% in Canberra and 39% in Carlton, Melbourne (Hurley, 2020). These students are important parts of the Australian community, extending beyond the economic impact into the social fabric.

Australia also has one of the highest temporary worker migration rates of any of the world’s democracies – between eight and ten per cent of the labour force (Badham, 2020). Over 900,000 temporary migrant workers are involved in building the nation from the ground level (Tham, 2020). China has emerged as the largest source jurisdiction of temporary visa holders with a work right in Australia, with India close behind, undertaking work in sectors with labour force deficits (Department of Home Affairs, 2020). However, many of them have reported experiencing systemic exploitation, unfair work conditions and job insecurity (Fels & Cousins, 2019).
On 3 April 2020, the Prime Minister announced that international students and people on temporary migrant visas should make their way home (Gibson & Moran, 2020). The announcement was made in the midst of border closures and international flight cancellations. Many of these affected students and workers and their families were stranded in Australia, facing employment and accommodation pressures. In the context of 'we are all in it together', it was effectively a declaration that the 'we’ here referred explicitly to a defined group of Australian citizens and residents. The Prime Minister also announced that there would be opportunities for visa holders who had critical skills and who would be able to assist in the coronavirus crisis (Gibson & Moran, 2020). Implicitly, this qualifies those temporary visa holders with the ambivalent construct of ‘essential 'skills (such as cleaning, aged care, health care, and education) useful in fighting the coronavirus. This also suggests that the cohort is of ‘lesser’ value than citizens and could be spared, if willing, to care for the citizens while they were asked to be responsible for their own health risks.

The systemic exclusion of groups of temporary visa holders, refugees, and international students invoked a racialised form of nationalism, legitimised by the conditions of the public health emergency. Episodic racism initially emerged in the form of anti-Chinese sentiment in February, and quickly multiplied, impacting many Asian-looking Australians and international students. A community survey conducted by the Asian Australian Alliance between April and June 2020 found over 377 incidents of racism against Asians in Australia, an average of 47 reported cases a week, particularly involving strangers targeting women. Asians were reported being physically harassed, threatened with weapons, spat at and told they couldn’t enter premises “because Asians need to stay indoors” (Chiu, 2020).

For international students, the government’s calls to live off savings or return home appeared as a betrayal of their contribution to the Australian economy through the lucrative tertiary education sector and their labour participation in essential industries (Lehmann & Sriram, 2020). By 31 August 2020, over 70% of international students were estimated to be stranded in Australia. Many reported that they could not go home due to various travel and financial constraints (Lehmann & Sriram, 2020).

Significantly, another recent study of international university students has indicated that 59% of the survey participants would not recommend anyone to come and study in Australia (Roe, 2020). This sentiment suggests a sense of betrayal. It is symptomatic of the consequences of the whiteness of policymaking in Australia, manifested in discriminatory pandemic responses. Worse, this increasing
distrust and dismay signifies an imprint in the visitors’ psyche that little change would occur in the future (Roe, 2020).

**RACIAL PROFILING IN AUSTRALIA’S PANDEMIC RESPONSE**

The issue of racial profiling has been a recurrent theme in Australia for decades (Police Stop Data Working Group, 2017), particularly in regard to several media agencies fomenting the notion of ‘Asian gang’ and ‘African gang’ crime problems (Donovan, 2013). More specifically, racial profiling has been identified by a ‘a practice whereby police, consciously or otherwise, systemically stop and search racial minorities on the basis of stereotypes rather than reasonable grounds to believe an offence has taken place’ (Police Stop Data Working Group, 2017). In the Australian context, for example, individuals of African/Middle Eastern appearance are found to be stopped and searched 2.53 times more frequently than the general Australia population. While it is not the express purpose of the intentional individual practices or overt organisational policies to target racial minorities, it is the effect that matters (Police Stop Data Working Group, 2017). Racial profiling contributes to alienation, worsening health outcomes, and perpetration of racial underclasses, amongst the various impacts (Police Stop Data Working Group, 2017).

This form of biased and discriminatory policing has been similarly evident in the implementation of public health policy during the COVID-19 pandemic response. This began with the systemic discrimination in the implementation of quarantine procedures. In the early days of the pandemic, in late January 2020, the Australian government announced that Chinese Australians returning from Wuhan would be sent to Christmas island, the site of a prominent detention centre in Australia’s asylum seeker detention programme (Xiao, 2020). The symbolism of Chinese Australians quarantining in a detention centre was in contrast to the preferential hotel quarantine measures introduced to accommodate emerging populations of predominantly white Australian tourists returning on cruise ships.

Although returned Chinese travellers in quarantine reportedly expressed few complaints and showed their appreciation for the assistance (Xiao & Broke, 2020), some asked whether white Australians would be treated the same way (British Broadcasting Corporation [BBC], 2020). Perceptions of similar modes of bias were also raised in regard to the initial implementation of travel bans targeting countries
such as China, Iran, and South Korea, with Italy only added later to the list despite “facing the largest outbreak outside China” (Hitch, 2020. np). Questions were asked as to why travel within the US remained open despite “the majority of Victoria’s new cases [being] connected to those who have travelled from the United States” (Towell, 2020, para. 1).

Emerging geo-political tensions between Australia and China surrounding the COVID-19 pandemic prompted increased anti-China rhetoric, prompting perceptions that being anti-China or anti-Chinese is no longer considered as being racist (Baker, 2020a). By 6 June 2020, China had issued a travel warning to prevent their citizens from travelling to Australia amid increased racism due to the COVID-19 outbreak. The Australian Tourism Minister Simon Birmingham rejected China’s assertions of Australian racism, reverting to the populist doctrine that “Australia is the most successful multicultural society in the world” (Department of Home Affairs, 2018, p. 7).

Racial profiling has also been a common, recurring theme in several Australian media agencies. In a series of events in July regarding several young women breaking isolation and quarantine rules to travel to Brisbane, the issue of racial profiling again emerged when they were identified, with their African backgrounds highlighted in tabloid media (News, 2020). Whilst community leaders acknowledged their conduct in putting “the whole community at risk”, they, alongside the affected families, reported a strong racist element within the public reaction. A relative of one of the young women commented to a journalist that “if someone else did this yeah, that wasn’t of colour, you’d be f**king protecting them” (News, 2020, para. 18). This emerging tendency for elements of the public and media to use public health culpability, perceived or real, to legitimise racial profiling and justify discrimination carries a similar sentiment to the anti-Chinese prejudice.

**THE MATTER OF BLACK LIVES**

The implications of racial profiling have been most evident in relation to the recent Black Lives Matter protests arising in the US. Protests in Australia, which focused on the disproportionately high rates of imprisonment and deaths in custody of Indigenous and Torres Strait Islander Australians, were politicised within the pandemic context. Thousands of protesters joined rallies in each of Australia’s state capital cities amidst threats of sanction and claims of social irresponsibility in regard to public health risks.
Protest organisers acknowledged the dilemmas in trying to “balance perceived risk with real risk” in holding mass public action under pandemic conditions whilst raising awareness of the implications of police violence and incarceration on black lives and the success of the indigenous health response. For many Indigenous Australians, the protests were seen as necessary to address the systemic racism that pervades the police and the criminal justice system (Langton, 2020). However, the popular discourse surrounding these events subsumed racial politics within the pandemic context, exemplified by the headlines such as “Did Australia’s Black Lives Matter protests cause a spike in COVID-19 cases?” (Baker, 2020b, p. 1).

Ideological polarities emerged, playing out in public debate, manifested in the view of Australia’s chief medical officer, Prof Brendan Murphy, that “these sort of events really are dangerous” which was countered by Professor of Aboriginal and Torres Strait Islander Health at Western Sydney University, Aunty Kerrie Doyle’s argument of negligible community infection whilst “there’s not a day when Indigenous people aren’t targeted” (Davey, 2020, para. 7). The debate escalated due to an article in The Australian, claiming a public housing cluster of COVID-19 infections could be linked to the Black Lives Matter protest in Melbourne, referencing comments by a police commissioner of a heightened health risk of protesters from public housing towers (Visontay, 2020).

Despite the claims of transmission links to the Black Lives Matter protests being refuted by health officials (RMIT ABC Fact Check, 2020), the stigmatisation of the BLM movement as irresponsible and anti-social became consistent with the racial polarisation trends under the pandemic. In promulgating a linkage between protest and public housing towers, the labels of risk, criminal act, and social irresponsibility were assigned to some of the most vulnerable, marginalised communities, predominantly identified in Australia by the term culturally and linguistically diverse (CALD).

**COMMUNITY DISENGAGEMENT**

On July 4, the Victorian government placed nine public housing towers in Melbourne under ‘hard lockdown’. This punitive approach, implemented in the form of a rapid police intervention, was questioned in its efficacy as public health policy. The public housing residents spoke of the traumatising effect of the police presence, inappropriate dietary provisions, poor communication, and the prevailing conditions of overcrowding, under-resourcing, poor hygiene, and inadequate maintenance (Carrasco, Faleh, & Dangol, 2020). According to a resident, the enforced lockdown is “a direct reflection of the
systemic inequalities in public housing” (Carrasco et al., 2020, para. 7).

The police intervention has undermined the social fabric and the sense of agency of the community living in the towers (Kenny, 2020). For decades, communities living in the public housing towers have been taking responsibility for their own well-being, often predicated on government neglect and the lack of service provision (Levin, Arthurson, & Ziersch, 2014). Whilst there are different ways in which they do this, the communities are involved in diverse and widespread efforts to provide material and non-material support and social connectedness.

The public housing lockdown represented an emerging pattern of state paternalism and xenophobia, disproportionately targeting migrant communities. The public housing towers were included in a grouping of local government areas designated as hotspots of virus incidence and transmission which were collectively also recognised as lower socio-economic and culturally diverse regions of Melbourne (Evershed, 2020). Whilst the testing blitz in these ‘problem suburbs’ in June sought justification as an appropriate health response to high rates of infection (ABC, 2020), it also perpetuated forms of stigmatisation. Furthermore, a report in August that police fines for non-compliance to pandemic regulations replicated these inequalities (Cooper, 2020) by disproportionately impacting CALD communities.

State government discourse, whilst maintaining the ‘we are all in it together’ slogan and acknowledging the challenges faced by vulnerable communities, has increasingly adopted a carrot-and-stick strategy. This has emphasised adherence to state rules and regulations to reduce infections towards the goal of removing lockdown restrictions. Targeted approaches in contact tracing, enforcing quarantine, and testing have reinforced notions of paternalism and, by stigmatising migrant communities has similarly invoked notions of coloniality.

The problem of coloniality is most evident in government neglect of engaged community-driven responses. Certainly, politicians and bureaucrats would be aware of the success of the indigenous community-controlled health approach. This raises questions as to why this model has not been replicated in vulnerable migrant communities. In the same way, indigenous self-determination has been described as vital to First Nation communities “beat[ing] COVID-19”, public housing residents and other migrant communities have identified a deficit in community agency (Walsh & Rademaker, 2020, headline). In perpetuating patterns of systemic racism, Australia’s governments have also undermined
the public health of these vulnerable communities.

**SOLIDARITY IN THE NEIGHBOURHOOD**

The impacts of government policy on international students, temporary migrant workers and those of less privileged background have been profound. Research has found that 65% of international students lost their jobs; 39% of the survey students did not have enough money to cover basic living expenses; 43% were skipping meals on a regular basis; 34% were already homeless or anticipated imminent eviction because they could not pay rent. Furthermore, there has been an increase in mental health issues, and health risks arising from being forced into overcrowded accommodation due to rent stresses (Berg & Farbenblum, 2020).

However, the combination of government neglect and survival imperative has prompted responses as acts of local and diasporic solidarity. There has been an upsurge of migrant communities (e.g. Sikh community) and restaurants (e.g. Thai restaurants) providing free food and community groups offering welfare support for international students in addition to food packages being provided by Australian charity organisations (Henriques-Gomes, 2020). Driven by local migrant-based information channels, whether online or by word-of-mouth, this support has provided an important form of community agency in contrast to the paternalistic pandemic response by government authorities. During the hard lockdown of the public housing towers, community groups similarly mobilised to provide halal food and other culturally appropriate food and support, while subject to the strict health controls imposed by authorities (Kenny, 2020).

**ELEPHANT IN THE ROOM**

Despite the call that 'we are all in it together', political decisions have clearly not benefited 'all', influenced by the coloniality and whiteness of Australian governments. The lack of lived experience and diverse representation within Australia’s parliament has been magnified by the crisis nature of the pandemic. The inability to fully grasp the issues associated with racial discrimination, casualised work and the mental health pressures surrounding migration create a deficit in the understanding of and policy implementation towards multicultural communities.
Although the Australian state and federal government responses have been popularly supported, the neglect and marginalisation of vulnerable communities has been subsumed within the discourse, stigmatising these communities for their higher incidence of COVID-19 cases. State-federal government policy initiatives providing financial support in Victoria in early August, through a pandemic leave disaster payment, included casual workers and temporary visa holders (Karp, 2020). However, it represented a belated acknowledgment of the health risks associated with unprotected casual work that is disproportionately performed by migrant communities. Similarly, efforts to translate public health information into different first languages recognised the need for appropriate responses to community contexts. However, this was in response to an acknowledgement that using the English language as the medium of public health communication was inadequate, despite government statistics identifying that one in five Australians speak a language that is not English at home (Australian Bureau of Statistics, 2016a).

The hard lockdowns across Melbourne, and state-wide throughout Victoria, in response to significant community transmission were consistent with the punitive approach taken in the public housing towers. However, in placing the onus on public behaviour associated with the areas designated as ‘problematic’ hotspots, governments were ignoring or deflecting from the ‘elephant in the room’ – the health and safety implications of economic inequities.

The COVID-19 pandemic has exposed the public health implications of systemic neoliberal inequities, with an Australian economist suggesting “the spread of coronavirus in Australia is not the fault of individuals but a result of neoliberalism” (Dennis, 2020, headline). For migrant workers and temporary visa holders, the combination of low income, inconsistencies in regulation, job insecurity, and working in multiple workplaces are commonplace (Fels & Cousins, 2019). With the risk of COVID-19 transmission heightened in workplaces designated as essential, such as age care, the financial insecurity of temporary visa holders has accentuated the status of migrant workers as at-risk.

The exclusion of temporary migrant workers from national income support programmes is not only perceived as contrary to the notion of being ‘all in it together ’but also being fundamentally unfair. According to Professor Tham, the Deputy Chair of Migrant Workers Centre, the matter even breaches a number of fundamental rights:
"Equal rights at work - regardless of migrant status - is a key principle of the Universal Declaration of Human Rights, the International Covenant of Economic and Social Rights, the International Labour Organisation standards on labour migration, and the UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. This principle underpins Australia's Fair Work Act which treats migrant workers as within its scope" (Tham, 2020, para. 9).

Whiteness and colonality, manifested in cultures of privilege, power, and the sense of entitlement, frame this notion of the 'elephant in the room' as representing the intersection of racial discrimination and insecure work. However, the ‘elephant’ is nuanced for many, best explained by a spectrum of racism, traversing casual to systemic racism. In the pandemic context, it spans the wilful ignorance associated with the systems and structures exposing the White Australia legacy to the unconscious bias evident in reactive public health policies.

CONCLUSION - SYMPTOMS OF ILLNESS, SYMPTOMS OF CHANGE

As the pandemic has entered the phase of second and third waves around the world, the prevailing discourse is that of sustaining a balance between limiting virus transmission, minimising economic impacts, and maintaining political stability whilst awaiting an effective vaccine. The language and imagery surrounding the ‘war’ against the viral ‘enemy’ underscores the scale of global disruption and transformation. However, the pandemic can also be viewed through the paradoxical lens of disaster and opportunity and its future implications for society at all levels.

The geo-political order is already repositioning in response to perceptions of the culpability of China, the dysfunctional pandemic containment responses of powers such as the USA, India, and Brazil, and the emergence of smaller countries with effective models of pandemic management. Similarly, the neo-liberal system has not simply been exposed for creating inequity but also unsustainable on public health grounds. Can the pandemic represent both a crisis for modern society and a circuit breaker in challenging such inequity?

The paradox can be seen in the humanist, civil society sentiment of ‘all being in it together’ contrasting with the disproportionate impact on vulnerable groups in society. In Australia, the acknowledgment of
the link between the transmission of COVID-19 and the insecure, casualised workforces in essential industries – such as aged care, security, and food distribution – poses questions regarding future workplace laws and regulations. It remains to be seen whether the post-pandemic era will be transformed by this scale of disruption or whether the evident inequities will become further entrenched. Returning to Arundhati Roy’s words, this will be defined by how we salvage the wreckage of the train.

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COVID-19: Violent Policing of Black Men During Lockdown Regulations in South Africa

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ABSTRACT

Drawing on media reports published during South Africa’s COVID-19 lockdown, this article argues that violent policing of black men in South African townships was driven by racial stereotypes which depict black men as unruly, defiant, violent and aggressive. Law enforcement officials’ use of violence is rooted within the social construct of hegemonic masculinities in which victims are positioned as villains, while law enforcement officials position themselves as heroes who are simply enforcing the rule of law. This article argues that the use of violence affirms law enforcement officials’ sense of manhood while undermining, shaming and marginalising young black men’s sense of manhood. Furthermore, the article posits that the lockdown regulations gave law enforcement officials additional power and authority, bolstered by the panic and fear associated with the risk of contracting COVID-19, to further criminalise young black men. Policing is not just a safety act but a gendered phenomenon which draws on other discourses of race and class in justifying certain acts of violence against poor, black working-class men.

Keywords: COVID-19, law enforcement officials, masculinities, violence, police brutality, South African politics, lockdown

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INTRODUCTION: SOUTH AFRICA’S RESPONSE TO THE COVID-19 PANDEMIC

On 26 March 2020, President Cyril Ramaphosa announced a set of strict regulations that would see South Africa enter a state of ‘lockdown’ in order to curb the spread of the COVID-19 novel coronavirus. Measures to be enforced included:

- Prohibition of all gatherings except for funerals
- Closure of restaurants, taverns, bottle stores and other stores not selling essential goods for the duration of the lockdown period
- A ban on the sale, dispensing, distribution and transportation of alcohol – except in cases where alcohol was required for industries producing hand sanitisers, disinfectants, soap, alcohol for industrial use, household cleaning products, and liquor for export purposes. In addition, no special or events liquor licences would be considered for approval
- A ban on the sale of tobacco products, e-cigarettes and related products
- Imposition of a curfew 20:00 until 05:00 daily, except in respect of a person granted a permit to perform an essential or permitted service, or attending to a security or medical emergency
- A moratorium on evictions and the staying and suspension of all orders of eviction until the end of lockdown level 4, unless overridden by a court
- A prohibition on people leaving their homes during the lockdown period other than to access health services, collect social grants, attend small funerals (no more than 50 people) and shop for essential goods

This is not an exhaustive list of the measures undertaken, but for the purposes of this article they are the regulations most relevant regulations for discussion. The implications of enforcing these rules had a considerable effect on South Africa’s social and economic structure, especially in poorer communities (Broadbent, Combrink, & Smart, 2020; Stiegler & Bouchard, 2020). Twenty-six years after the end of apartheid, South Africa is, according to the World Bank’s calculations, the most unequal country on earth (Beaubien, 2018). This is compounded by the fact that, as of October 2020, South Africa had the highest rate of COVID-19 infections in Africa and the twelfth highest in the world (Worldometer, 2020). After announcing the lockdown regulations aimed at curbing the spread of the pandemic, the South African government deployed the army and the police to ensure that people obeyed the regulations (BBC, 2020). However, these law enforcement officials were deployed only in township areas, raising questions about racial profiling, stereotypes and discrimination (Trenchard, 2020). Over
100 000 troops were deployed by the South African government, leading many to speculate that the country would come to resemble a military state (Maseko, 2020). According to a vast number of cases reported in the media, it seems that this indeed came to pass. Many images and videos were broadcast of law enforcement officials running rampant through the dusty township streets, shouting at and manhandling residents (Mahamba, 2020). Law enforcement officials targeted rule breakers, arresting an estimated 200 000 people while warning or fining many more for relatively petty infringements (BusinessTech, 2020). These arrests disproportionately targeted poor black South Africans. Police have been criticised for their heavy-handedness in enforcing the rules, at times resorting to deadly force and with many accusing Police Minister Bheki Cele of implementing a ‘skop, skiet en donder’ approach – an Afrikaans apartheid-era police term meaning ‘kick, shoot and beat people up’ (Hansen, 2006). This was the approach was employed by the Afrikaner National Party government in the apartheid era as a method of completely erasing any resistance by black South Africans, and also violating their rights (Mathabane, 1986).

This article explores the violent policing of black men under the Covid-19 lockdown regulations in South Africa as well as how the constructs of gender and race are deployed by law enforcement officials attempt to justify their violent acts against poor black working-class men.

VIOLENT POLICING IN SOUTH AFRICA: CONTINUITIES OF THE PAST IN THE PRESENT

South Africa has a long history of violent policing under apartheid (Bruce, 2002). However, it appears that despite the transformation of law enforcement agencies post-1994, violence against young black men continues to be a major human rights problem in South Africa (Dissel, Jensen, & Roberts, 2009). Statistics released by the Independent Police Investigative Directorate (IPID) show that over 4 000 cases of torture and assault were reported against law enforcement officials between 2012 and 2019 (Kempen, 2020). These numbers show that acts of violence against civilians by law enforcement officials were common, even prior to the implementation of the lockdown regulations.

Policing generally draws on practices of hegemonic and militarised masculinities based on notions of toughness, fearlessness, bravery and willingness to use violence (Langa & Eagle, 2008; Whitehead, 2005). The interdependence of masculinity and police or military violence has been recognised by many social scientists working in the field of policing and the military (Prokos & Padavic, 2002; Whitehead, 2005).
A central contention is that law enforcement officials often rely on a set of social practices, symbols, discourses and ideologies associated with the category of ‘man’ to perpetrate any form of violence or abuse (Whitehead & Barrett, 1994). Other markers, such as race and class, are also used by law enforcement officials in policing certain bodies. In popular discourse, the black man is often constructed as the perpetrator of violence and thus a figure to be feared. The police also rely on these racist stereotypes in the policing of young black men, whom they consider to be potential criminals and of whom people need to be wary as a ‘threat’, the implication being that they may steal, rob or break into houses. A station commander in Cape Town was quoted in Jensen’s (2008, p. 128) study as saying: ‘Your average law-abiding citizen lives in specific middle-class areas, whereas the problematic groups live in the townships; you can say most people in the townships are gangsters.’ Given this view, it is common for law enforcement officials in South Africa to use violence against young black men, who are stereotypically seen as unruly, aggressive and violent (Jensen, 2008; Langa & Merafe, 2011).

MILITARISED ENFORCEMENT IN SOUTH AFRICA DURING COVID-19 PANDEMIC

The violent policing and killing of black men living in South Africa’s townships by law enforcement officials during the height of the COVID-19 pandemic highlight the human rights violations perpetrated by these officials (Nicolson, 2020; Seleka, 2020). For example, Petrus Miggels, a 50-year-old black man, was assaulted on the first day of level 5 lockdown after being found carrying alcohol, which was prohibited (Knoetze, 2020). Following a violent altercation with police in Ravensmead, a township in the Western Cape, he was dragged into a police vehicle. A short while later Miggels was dropped off near where he had been picked up, visibly shaken, and died within an hour (Knoetze, 2020). In another case, it is alleged that a 40-year-old black man living in Alexandra township, Collins Khosa, had beer poured over his head by South African National Defence Force (SANDF) officials after he was found drinking with his friends on Good Friday (Seleka, 2020). According to court papers, he was forced to hold his hands behind his back while being choked, kicked, punched and slammed against the wall (Seleka, 2020). The officials also used the butt of a machine gun to beat him and he died from injuries sustained due to blunt force trauma to the head (Nicolson, 2020). Finally, Sibusiso Amos, a 40-year-old black man living in Vosloorus township, was shot dead on the veranda of his house by a metro police official and a private security guard (Mahlakoana, 2020). He was alleged to be smoking near his
SANDF members also reportedly forced people to do humiliating things, such as lie down in the mud and do push-ups and frog jumps (Makinana, 2020). Despite calls for members of the SANDF to show restraint when dealing with civilians during the ongoing national lockdown, the ANC in Parliament praised soldiers for what it called ‘simple measures to discipline community members’ (Makinana, 2020). This represents two pervasive features of hegemonic masculinity, as conceptualised by David and Brannon’s (1976) masculinity typologies: the tenets of ‘Give ’em hell’ and ‘No sissy stuff’, both of which played out during South Africa’s lockdown. The SANDF clamped down with impunity on the smallest of infractions, even sometimes simply because citizens did not listen to officers even though they were not disobeying any lockdown regulations (Makinana, 2020). Push-ups and frog jumps were intended to punish offenders and coerce them into not showing ‘sissy stuff’ if they could not complete the exercises. These punishments were imposed despite the health risks involved in assuming that all people possess the physical fitness to do such exercises. In addition, underlying medical conditions may be exacerbated by strenuous activity (McInnis, 2000).

A video of a 28-year-old black man from Cape Town named Bulelani Qolani was widely distributed on social media. The video shows him being dragged naked out of his shack by metro policemen who accused him and his neighbours of illegally building shacks on land belonging to the City of Cape Town (Kassen & Fisher, 2020). His removal was, however, not in line with President Cyril Ramaphosa’s declaration that all evictions were prohibited during lockdown (Kassen & Fisher, 2020). Stripping someone of their dignity is a fundamental human rights issue. When Qolani was interviewed in the media about his experience of being dragged out in the public, naked, he stated that he wanted his dignity to be restored. He was quoted as saying, ‘I thought they would have empathy, because if you drag a Xhosa man naked in public like that, you have killed him. By doing so, you are not only attacking me, but you are attacking all Xhosa men’ (Kassen & Fisher, 2020). The construction of masculinity is overlaid with cultural practices, in this case the Xhosa cultural belief that a man who has not been to initiation school is considered a boy, regardless of his age, while a ‘real’ man is one who has gone to initiation school (Mgqolozana, 2009). Being seen naked in front of other men is granted under initiation rites only, and therefore given cultural significance. The experience of being seen naked was not only embarrassing to Qolani’s dignity as an individual but to his whole culture as a Xhosa man.
MALE-TO-MALE EMASCULATION AND HUMILIATION

In all the incidents described above, both the victims and the perpetrators are men. These instances of violence and abuse cannot be attributed solely to lockdown regulations. Rather, violence is used by law enforcement members as a means of instilling discipline and asserting power over other men. This links with Connell’s (1995) definition of hegemonic masculinities being about having domination over other men. Men in law enforcement hold hegemony over other men, given the authority accorded them by the state to act on its behalf in enforcing the rule of law. The authority becomes gendered due to the relationship between gender and power (Connell, 1995). Therefore, the violence that law enforcement officials perpetrate highlights something significant about violence and manhood: it is through man-to-man violence that some men can demonstrate their hegemonic manhood (Whitehead, 2005). The man who is abused, tortured or killed loses his status as a man and is rendered unmanly; he is emasculated. It must have been a humiliating experience for the 50-year-old Miggels to be assaulted by law enforcement officials. Neighbours described him as a shy man who respected everyone in his community (Knoetze, 2020). The ages of his perpetrators are not known but they are more than likely to be younger than him. It is emasculating for an elderly male to be beaten up by a younger person (Whitehead, 2005), but law enforcement officials in this situation were drawing their power and authority from the positions that they occupied. The act of pouring beer over Khosa’s head was to shame and humiliate him in the eyes of those who were witnessing this abusive moment. Jensen (2008, p. 129) argues that it is during these violent encounters that victims are treated as ‘assholes’. This process of emasculation and humiliation can occur only if the violence or abuse is perpetrated by one male against another. Similarly, with respect to the other abuses reported in the media, victims were forced to do push-ups and frog jumps in order to humiliate and emasculate them. It is known within policing and military circles that one must withstand any pain associated with such training exercises (Faul, 2011; Prokos & Padavic, 2002; Whitehead & Barrett, 1994). Those who fail to endure the pain are called derogatory names such as wimp, puss and sissy boy, all labels with a feminine connotation (Prokos & Padavic, 2002; Whitehead & Barrett, 1994). Hegemonic masculinity can only be confirmed in relation to the other, confirming the view that this gender identity does not exist in isolation. It exists in the subordination of other men (Connell, 1995).
BLACK MALE-TO-MALE VIOLENCE

The vast majority of law enforcement officials in South Africa are black men (Newham, Masuku, & Dlamini, 2006). This means that a link can be drawn between notions of African masculinity and violence. It is clear that the lockdown regulations further entrenched violent policing practices. IPID reported that more than 300 cases of human rights abuses committed by law enforcement officials during this period were brought forward, including torture, assault and murder (Knoetze, 2020; Tracey-Temba, 2020). Many of the victims were young black men, while the perpetrators were mainly black male law enforcement officials. South African policing under apartheid was highly racialised, but the post-1994 era has not changed entrenched racial stereotypes on how black men are seen in relation to law and order. Ratele (2013) questions the applicability of Connell’s notion of hegemonic masculinity, especially in explaining male-to-male violence among black men. He argues that some black men (in this case, black male officers) may be perpetrating violence against fellow black men, but this does not mean they occupy a position of hegemony as proposed by Connell. Ratele (2013) asserts that they occupy a hegemonic position within the context of marginality. Black male officers, despite being black themselves, draw on the same stereotypes that black men are unruly, violent and aggressive. Ratele (2013) claims that the system of racism, linked with capitalist economic structures, psychologically and mentally brutalises black men, whether or not they have power. Andrew Faul’s (2011) book, *Behind the Badge: Untold Stories of South African Police Service Members*, details stories of how black male officers came to join the service. Faul concludes that many did not want to be police officers, but a lack of opportunities and other career prospects due to high levels of unemployment left them with no option. In their stories, there was an element of the anger, hurt and trauma associated with their work (Faul, 2011). Violent black masculinities cannot be divorced from the history of colonialism and apartheid, which resulted in the formation of townships such as Alexandra where Collins Khoza was killed during lockdown.

Human rights activists have criticised security forces who were deployed to enforce lockdown regulations, mainly in poor black areas such as the high-density townships where high population numbers and overcrowding made it virtually impossible to self-isolate. ‘COVID-19 has exposed the brutal inequality in South Africa,’ said Chris Nissen, a commissioner from the South African Human Rights Commission in an online newspaper interview (Businesstech, 2020). Nissen went on to ask, ‘People say all lives should matter, but what about people in townships? Don’t their lives matter too?’ (Businesstech, 2020). His remarks were made in the midst of worldwide marches in support of the
Black Lives Matter movement, following the killing of George Floyd and other young African American males in the United States (Barbot, 2020; Camacho et al., 2020). Do the lives of young black men matter in South Africa? They also continue to die at the hands of law enforcement officials beyond the COVID-19 era. Why are there no marches or public condemnations of such killings or abuses? It appears that black lives matter, but they do not matter equally. The killing of 34 miners in Marikana, among them Andries Tatane and Mido Macia, remains a constant reminder of police brutality and violence post 1994. Class politics are at the centre of this violence: it is mainly poor young black men who are at risk, given their precarious socio-economic circumstances and living conditions. These violent policing masculinities have become more public during the COVID-19 crisis. It is therefore important that alternative non-violent, non-sexist, and non-homophobic masculinities are promoted among law enforcement officials.

CONCLUDING REMARKS

The world has become more precarious because of the coronavirus pandemic. The lockdown has already resulted in widespread job losses, while many economies worldwide are likely to face recession. This article has looked at how young black men in South Africa were policed during the lockdown period imposed in response to the COVID-19 pandemic. The dynamics of this violence appear to be rooted within a hero–villain interaction, based on racist stereotypes in which young black men are perceived negatively. Men consider other men to be worthy opponents to fight or perpetrate violence against to achieve power and authority. According to Whitehead (2005), this leads to ‘heroic masculinity’ – the man who ‘wins’ the fight is accorded the status of being a ‘real’ man and the one who is defeated is considered weak. Dominance has to be constantly reiterated through threats or the enactment of violence against another male. This hero–villain dynamic, rooted within hegemonic masculinities, explains why male law enforcement officials perpetrate violence against young black men. Their working-class position as poor members of society exacerbate their vulnerability to these abuses by those in positions of power and authority. Most of the violence meted out for lockdown violations was perpetrated by a black police force against black citizens, prompting the question of whether institutional racism and discriminatory prejudices still inform law enforcement in post-apartheid South Africa (Bruce, 2002). Alternative non-violent, non-sexist, non-racist and non-homophobic policing masculinities need to be promoted among law enforcement officials beyond the COVID-19 era.
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The Politics and Art of Naming and Re-presenting Identity in the COVID-19 Pandemic

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ABSTRACT

The body has long been considered a site of oppression. The pandemic has highlighted this once again as disadvantaged people and those from racial and ethnic minorities are disproportionately affected by COVID-19. I argue that language, and specifically naming, is used as a tool to constantly redefine the Other, keeping them in a constantly undefined identity state. This constant redefining perpetually delays any imperative for the oppressor to correct structural oppression, as the oppressed remain unknown. Simultaneously, the oppressed are blamed for their own disadvantages, further detracting from the process of addressing structural disparities. Using language and naming to constantly redefine and re-present marginalised identities as undefined has been a less recognised tool of oppression. This represents a kind of suffocation of identity. Conversely, activists have used language, often the very language that has been used to oppress in artistic forms to protest oppression and suffocation of identity. Artistic forms of protest through language are political and have persisted in the face of structural violence.

Keywords: Identity; ethnic minority; black lives matter; arts in health; poetry

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COMBAT BREATHING…
   By Thirusha Naidu

What is the price of a breath?
When the air charged
With the unprecedented use of The Word
‘Unprecedented’

Race for a vaccine?
What we need
is a vaccine for Race.
That is a virus that never stopped.
Replicating.

Breathing is for granted.
The air just there.
“Our protest is our breath”
Who has the riot?
Who the protest?
Flip the bird!
The Revolution is being televised
in black and white.

In an era of respiratory politics
“the individual’s breathing is
An observed breathing
Combat breathing”
Suffocate until you learn
Need is Black and Aid is White.

Floyd begged in futility
for the privilege of AIR.
Jordon would have gasped too.
Were he not tall, Black and talented.
Like Bantu\(^2\) said before,
“Black man you’re on your own”


\(^2\) Steven Bantu Biko – South African Black Consciousness leader killed by Apartheid police.
They were made of deconstructed and repurposed Nike Air Jordan sneakers. In a simultaneous flipping of the mind and senses I had encountered the work of Indigenous Canadian artist Brian Jungen. Hundreds and hundreds of red, black and white Nike Air Jordan sneakers re-fashioned into totem poles, head dresses, masks and, at a distance, undiscernible from ‘the real thing’. My two young sons, future dark-skinned men from a dark-skinned mother, looked to me for some insight into why Jungen would do such a reprehensible thing to perfectly good shoes. I explained that he was telling a story, an old story. His story? Their story? He was telling tales about sports fields being modern battlefields, about men (women still hold less value) being bought and sold for their talent, about people taking pride in manufactured and marketed icons as replacements for their ancestral treasures and collective souls. Jungen, I said, was telling how constantly replaceable merchandise had become a substitute for timeless traditional icons and how stable economy is now a substitute for stable identity. Through his sculptures, Jungen revealed that the dominants appropriated what was most precious to those they wanted to dominate and repurposed it as a means of control. Big words for small boys.

COVID-19 LANGUAGE – NAMING THE ‘OTHER’ AS COMPLICIT IN THEIR EXPIRATION

Nine months later, COVID-19 descended on the planet and the ground shook beneath our feet. Everything that seemed to matter before had to be abandoned for the common purpose of our survival as a species. At least until we came to learn that the virus did not affect us all equally. At the start, it seemed that the affluent global travellers and modern city dwellers were more susceptible. The poor and marginalised breathed premature sighs of relief. It was to be their last carefree breath as, soon, the virus found its way to the most vulnerable, following the infamous, well-travelled highways of the social determinants of race and poverty. People in black and ethnic minority communities in the global North were disproportionately assailed by the virus. These communities are suffering higher infection and death rates, prompting focused research into the issue (Naidu, 2020).

I use the terms “black” and “ethnic minorities” with a prickly disquiet, wincing at the thought that I am complicit in the tacit but insidious violent politics of naming to control. Words that denote people, places, events, actions and things are essential components in the linguistic portfolio of a culture. Names, and their meanings, comprise the systems that compose and shape our perspectives, understandings and imaginings of the world. Consequently, they extend beyond simple representation
of reality, alluding to value-laden semantics that sanction and reproduce power. Approved names are rooted in wider political narratives, hence names, and the authority to name, are fundamentally political, based on the power relations they reference and the discourses and social performances they enable and impede (Lynch, 2016; Peteet, 2005).

The occupation of country or territory is necessarily the occupation of the bodies of its people and the stifling of their way of life to ‘combat breathing’ (Fanon, 1961). Fifty years later, Fanon’s words resound prophetically within the COVID-19 pandemic where the virus is characterised by suffocation from the inside out. In seemingly unnerving co-incidence, smothering, structural and racial oppression that asphyxiates from the outside in, blustered into consciousness, driven by the Black Lives Matter movement. This human health crisis that was COVID-19 laid bare the racialised dynamics of health, economics and race which had, up to then, remained hidden in plain sight (Clark & Hurd, 2020; Devakumar, Shannon, Bhopal, & Abubakar, 2020; Dyer, 2020; Holmes et al., 2020; Pan et al., 2020).

In the emergence of race and ethnicity issues in the COVID-19 pandemic, I learned for the first time of the acronym, BAME (Black, Asian or Mixed Ethnicity), used predominantly in the United Kingdom. In the United States the equivalent term appears to be BIPOC (Black, Indigenous or People of Colour). Usually in close visual or auditory proximity are the terms overcrowding, poverty, transgenerational families and immigrants.

Who gets to do the naming and who is named highlights the structural violence inherent in having the power to rename the oppressed and to blame them for their suffering? The bodies of the marginalised or rejected Other has long been the site of battles – to be sacrificed, experimented and contested in the process of domination. The bodies of black people used in slavery as commodities, the bodies of Jewish people used in the Holocaust for heinous medical experiments, the murder of hundreds of anti-apartheid activists during South Africa’s apartheid and the unchecked murder of Indigenous women in North America. At each turn, the artful renaming of the Other makes it appear that oppressors have just recently come to realise that such an oppressed group exists. The process of constantly renaming and redefining the oppressed takes attention away from the work of redressing structural disparities. For as long as those in power are still attempting to determine who people are, they cannot listen to or directly address the concerns of the oppressed. People of African descent have gone from being ‘Negro’ to being ‘Black’ to being ‘African-American’, and then back to Black during the COVID-19 pandemic. Indigenous people in North America have been ‘Indian’, ‘Native American’ and ‘Indigenous’, despite having their own legitimate ancestral names. It would appear that each new renaming holds with it the promise of an ever-elusive respect, equality and access to resources which never quite materialises. At
the same time, there is a constant social subtext of disparaging and derogatory naming which evolves at the same pace and seems to reflect the underlying processes that prevent dismantling of oppressive structures.

The COVID-19 pandemic has converged on the age-old racism pandemic that inflicts the greatest risk on the racialised Other. Within health and healthcare, this has been inherent in the structural racism whereby marginalised people continue to be underrepresented globally in research and health-related professions. This is especially apparent in the global North where disparate infection rates between whites and ethnic minorities have been evident. Epigenetic and transgenerational susceptibility to disease is carried in the bodies of the oppressed and transmitted to their descendants. Research in the field of epigenetics has demonstrated that ethnic and racial groups who have been historically traumatised and oppressed have a higher susceptibility to mental and physical illnesses. This inherited vulnerability impacts on immunity (Sanz, Randolph, & Barreiro, 2018). Recent evidence indicates that whilst humans have always been a globally migrant species, forced displacements (slavery, indenture, forced migration etc.) under traumatic and violent conditions greatly hamper the ability of people to survive in their new environments. While data on ethnicity and COVID-19 in the published literature is limited, grey literature points to marginalised and ethnic minority individuals being at increased risk and having poorer clinical outcomes than white individuals (Pan et al., 2020). The presentation of race and ethnicity as purely social constructs which may be sanitised via the process of renaming becomes abhorrent when race and ethnicity is recognised as imposed on the body, situated in bodies by oppressors and experienced and suffered in the body of the oppressed.

My ‘too-sensitive’ ‘paranoid’ self hears the implicit othering and blaming of the affected for their circumstances and conditions and recognises this as la facultad, the faculty to capture the depth of the soul, the self. A version of myself which breaks the habitual modes of seeing reality and the patterns of consciousness, which do not reside in reason but in the body (Anzaldúa, 2012). Similarly, this sensitivity or paranoia was recognised by Fanon as the oppressed always having to be on the alert, because the many symbols of the colonial world can never be fully recognised so the oppressed can never be sure whether the frontier has been transgressed. Anzaldúa and Fanon’s borderlands people are caught in the paradox of being born in a space where they are not recognised as legitimate, or where they are categorised as different. This relegated, marginalised, subjugated, amorphous body is susceptible to social, historical and biological viral invasion. In these terms the ‘outsider’, ‘marginalised’, ‘non’ identity is underlying (Fanon, 1952). This oppression stifles the building of
identity such that the oppressed is forced to build identity in relation or opposition to the oppressor and is inevitably judged as the ‘Other’, less than and culpable for their own oppression, illness, poverty, exploitation and even death (Fanon, 1952; Pinter, 2005; Reny & Barreto, 2020). Try as you might, you cannot be white.

How will I define my own identity in respect of my own needs, wants and aspirations in the world and those who are similar to me? I have been Indian in South Africa and South African in India, black during some periods of Apartheid and brown in others – never white. In North America I learned for the first time that I was South Asian – not just Asian. Another name to ‘place’ me in the world of Others. For my information, a woman on a Greek island once insisted I was ‘West Indian’… When will the time come when I am no longer seen as a ‘non’ in need of a label? I take cold comfort in that I am not and have never been alone in my wondering. Anzaldúa writes on realising the power to speak in multiple voices, “I will no longer be made to feel ashamed of existing. I will have my voice: Indian, Spanish, white. I will have my serpent’s tongue…” (Anzaldúa, 2012, p. 81). All this naming and renaming is in service of maintaining the current structures of racial dominance and power. These names label the ‘Other’. We see easily, how what is missing literally and by implication in these labels are the names ‘white’, ‘Western’ or ‘Northern’ ‘male’, ‘powerful’, ‘pure race’ and ‘healthy’.

EXHALING – APPROPRIATING LANGUAGE AS ARTFUL PROTEST

In Fanon’s view, the occupied territories of land and body reflect dominant groups’ ideals to control the breathing of the dominated, to the point of suffocation (Fanon, 1961). The dominated must concede to breathing air apportioned at the whim of the dominant, or expire, the dominant’s intention being to control, utterly. This is operationalised by replacing and obscuring all semblance of local identity with the structures, systems and icons of the dominant invader. Resistance to invasion may take different forms but the reference point, when the intention is structural dominance, is often shackled to the power and positionality of the dominant group. While ‘combat breathing’ can refer to suppression of breath, as in Fanon’s estimation, it also describes a controlled, mindful, conscious breathing-to-survive under the threat of annihilation. Artists, writers and poets sublimate oppression through their works, demonstrating resistance that turns the oppressors’ methods against them. The power in this is seemingly passive resistance is that resistance is subverted and hidden in plain sight. Art as resistance can perform unassumingly in aesthetic spaces, biding time until the social world erupts to a point where seeing what artists’ messages are is inevitable and even essential. Art tunes into the coming zeitgeist
and breathes it into awareness. The structural discrimination COVID-19 has brought into sharp focus what has long been reflected in the works of artists who express the dynamics of oppression in word and form.

**RECLAIMING NAMING AS POLITICAL ACTION**

Through language, poetry can use both form and meaning powerful enough to create a political space. American poet Toni Morrison (Tahsin can, 2020, np) writes

> Most of the good poetry is also political, you can feel the heartbeat; its about some situation that concerns human being under duress. It’s suggesting a solution or just acknowledging [that the situation] exists. Art does that.

It is perhaps synchronous then, rather than co-incidental, that many poets have been politicians. Chilean poet and politician, Pablo Neruda (1971, np), writes that “Political poetry is more profoundly emotional than any other”. This is also evident in the words of Indian poet laureate and politician and civil disobedience activist, Sarojini Naidu, “I am not ready to die because it takes infinitely higher courage to live.” The message that if one is not heard in the spaces of power one has to speak in a different way is evident in the poetry of poets and gender and anti-racist activists, Gloria Anzaldua, Audre Lorde and Toni Morrison. All realised, outside of their actions as social activists and academics, that using language differently, in ways that disrupt and confuse, as poets do, calls attention to what matters, more finely and persistently, at times, than overt activism does.

This intersection of art as a means of protest action in the context of social oppression and suppression of oppressed peoples’ identity is that art speaks the truth to power. Art speaks our truth when it resonates with how we see the world and ourselves. The COVID-19 pandemic has highlighted once again that the historical socio-politics of race and discrimination is not only an invasion of space, place and identity, but an invasion of the body that can quite literally become life threatening. This invasion is apparently legitimised within the structures that uphold it, simultaneously othering and blaming the renamed and surreptitiously solidifying the place and the power of the dominant. Artists such and Brian Jungen and poets and writers such as Pablo Neruda, Toni Morrison, Gloria Anzaldúa, as well as countless others who are writing now and have yet to be heard, disrupt and trouble the foundations of these structures, dismantling and reconstructing them in ways that reveal how they oppress.
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COVID-19 Pandemic and Disability: Essential Considerations

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ABSTRACT

People with disabilities have greater healthcare needs and are more likely to experience poor health, however, their access to healthcare remains compromised compared to people without disabilities. Despite this well recognised need, people with disabilities often face barriers to accessing healthcare and they face additional risks to their well-being, because of the ongoing COVID-19 pandemic. In this paper, we posit that people with disabilities are vulnerable in the context of the COVID-19 pandemic. We demonstrate this vulnerability through briefly highlighting eight key considerations, as they relate to disability and COVID-19. We conclude that both inaccessible healthcare systems and the presence of underlying health conditions put people with disabilities at additional risk. Further, vulnerability to severe illness and death, post-contracting COVID-19, is exacerbated by the interaction between impairments and personal and environmental barriers existing at different levels, resulting in a...
disproportionately negative impact for people with disabilities. It is thus not sufficient to look only at underlying medical conditions as an indicator of risk for contracting COVID-19. Additionally, the challenge posed by not routinely collecting data on disability renders potential difficulties in linking disability to COVID-19 deaths/infections. More research is needed on disability and COVID-19 to inform disability-inclusive pandemic responses.

Keywords: Disability, COVID-19, inclusion, South Africa, healthcare

INTRODUCTION

According to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 1 (United Nations [UN], 2006, p.4), people with disabilities include “those who have long-term physical, mental, intellectual or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others”. Approximately 15% of the world’s population has some form of disability (World Health Organization [WHO] & World Bank, 2011; WHO, 2018). Most people with disabilities are located in the global South, because of the intersection between disability, poverty and rurality, which heightens barriers to health, rehabilitation, education and work (Grech, 2015; Grut, Mji, Braathen, & Ingstad, 2012; Mutwali & Ross, 2019; Sherry, 2015; Vergunst, Swartz, Mji, MacLachlan, & Mannan, 2015; Vergunst, 2016; Vergunst et al., 2017; Visagie, 2015). In South Africa, as per the 2016 Community Survey (Statistics South Africa, 2018), people with disabilities constitute 7.7% (3.8 million) of the total population. Consistent with international trends, the ageing population in South Africa is also disproportionately represented in disability populations (WHO & World Bank, 2011; Statistics South Africa, 2018). With the rise in life expectancy, more than half of the population aged 65 years and older, as well as approximately eight in 10 people aged 85 years and older, are reported as people with disabilities (Statistics South Africa, 2018).

People with disabilities are more likely than those without disabilities to experience poor health. For instance, an international study, across 30 countries, showed children with disabilities to be five times more likely to report illness as compared to those without disabilities (Kuper et al., 2014). However, despite experiencing a greater need for healthcare services, the one billion people with disabilities worldwide are “left behind” in healthcare (Kuper & Heydt, 2019; UN, 2018; WHO & World Bank, 2011). What further exacerbates the issue, is that some impairments require specialised services, such as medical and rehabilitation expertise and assistive devices (Kuper & Heydt, 2019), but these are not
always available for those in need residing in low- and middle-income countries (Bright & Kuper 2018; Bright, Wallace, & Kuper, 2018; Gupta, Castillo-Laborde, & Landry, 2011; UN, 2018). This is particularly concerning, considering that access to healthcare, including medical, rehabilitation technologies and assistive devices, is crucial to enabling effective and sustained access to education and employment and, thus, the capacity to earn a living to prevent hunger and poverty. The picture is similar in South Africa, where the health system is in crisis and people with disabilities remain on the margins (McKinney, McKinney, & Swartz, 2020). Within the South African context, literature shows that people with disabilities are subjected to poorer access to healthcare, are more likely to report illness and experience a greater need for these services, as compared to those without disabilities (Grut et al., 2012; Mutwali & Ross, 2019; Sherry, 2015; Vergunst et al., 2015; Vergunst et al., 2017; Visagie, 2015). Against this background, the COVID-19 pandemic may illuminate the magnitude of these existing challenges.

Data for this paper was obtained from a research project, where a rapid review of key considerations for people with disabilities, as informed by both current discussions about COVID-19 and existing literature about the status of healthcare access for people with disabilities, globally as well as within the South African context, was conducted. Key documents, which informed these thematic areas, against the reviewed literature, for the deductive analysis were the UN report (2020) on considerations for a disability inclusive response to COVID-19 as well as the WHO (2020) report on disability considerations during the COVID-19 outbreak.

**DISABILITY INCLUSION AND THE CONTEXT OF COVID-19**

It is important to note that, while people with disabilities experience greater healthcare needs to those without disabilities, during pandemics such as COVID-19, the healthcare crisis and needs of people with disabilities are more far reaching. In addition to all the general issues of healthcare access for people with disabilities, during the COVID-19 pandemic, there are a number of additional considerations, which we will discuss briefly. In keeping with the social model of disability, we have deliberately not categorised people with disabilities into specific groups (i.e. all people with physical disabilities), since no two people with disabilities experience disability and barriers in the same manner. Most barriers faced by people with disabilities are a result of external factors such as societal negative attitudes towards disability, a lack of accessible transport or appropriate communication rather than general intrinsic factors (Barnes, 2012; Shakespeare, 2013).
1. **People with disabilities are among the most vulnerable to contracting COVID-19** and may experience severe morbidity and greater risk of mortality following the infection. As WHO (2020) announced recently, people with disabilities (and, more so, those with underlying conditions) are at higher risk of developing serious illness following COVID-19 infection and are more likely to die. Many adults and children with disabilities have a compromised immune response or respiratory function (e.g., people with cystic fibrosis or quadriplegia), or risk factors for COVID-related mortality, such as cardiac disease, hypertension or diabetes mellitus. Older people are at greater risk of becoming seriously ill from COVID-19 and, given that many older people are classified as having disabilities, their risk is potentially compounded. This is supported by data from both China and Italy (Guan et al., 2020; Nurchis et al., 2020). In addition to the above inherent vulnerabilities, other studies show that people with disabilities are four times more likely to die or be injured during COVID-19, due to a lack of disability inclusion in health policies, planning and practice (Armitage & Nellums, 2020; Pineda & Corburn, 2020).

2. **The health risks posed by COVID-19 may be worse for people with disabilities in some contexts with underresourced health systems** (Whiting & Handley, 2020). For example, in South Africa, access to healthcare has been documented as a challenge for people with disabilities in underresourced areas, such as the Eastern Cape (Grut et al., 2012; Vergunst et al., 2015; Vergunst et al., 2017), Northern Cape (Visagie, 2015) and other provinces (McKinney et al., 2020; Mutwali & Ross, 2019). Such underresourced contexts place people with disabilities at a higher risk for morbidity and mortality. Increased pressure on regional health systems, due to rising COVID-19 infections, may result in people with disabilities not receiving adequate or appropriate medical attention. Due to a number of differing factors, including a lack of awareness, language and communication barriers, cognitive and communicative impairments, dexterity challenges and technological challenges, many people with disabilities were not able to access therapeutic services via telephone or online platforms.

3. **People with disabilities may find it harder to access routine medical and rehabilitation services and may be de-prioritised if critical care resources such as intensive care unit (ICU) beds and ventilators are limited**, which, consequently, violates their right to equal healthcare access (Liddell et al., 2020; McKinney et al., 2020). As Moodley (2020) states, the rationing of critical care facilities is a reality where there are resource constraints and rationing decisions may disproportionately affect people with disabilities. However, attitudinal and systemic barriers are likely to leave people with disabilities behind. Such attitudes may disproportionately shape
decisions on distribution of resources and services during COVID-19, in contexts characterised by inadequate health resources and limited capacity. Various studies already revealed the lack of capacity among service providers to treat people with disabilities and address the stigma, exclusion and discrimination that people with disabilities are subjected to, across health sectors (Kuper & Heydt, 2019; Leocani, Diserens, Moccia, & Caltagirone, 2020; Ned & Lorenzo, 2016).

In South Africa, de-prioritisation was also evident in how key disability-specific health services were not considered as essential services during the initial stages of lockdown (McKinney et al., 2020). De-prioritisation also left some people with disabilities without personal assistants, while others were without assistive devices and technology services, rehabilitation services, therapeutic and developmental interventions, and without sign language interpretation services for people who are deaf (McKinney et al., 2020; Mulibana, 2020).

4. Given that access to information remains a barrier to healthcare access (Meyiwa, 2010; Ned, 2013; Ned & Lorenzo, 2016), **people with disabilities may fail to access health information and communication on prevention measures, as it is often not provided in accessible formats**. This emerged as a serious issue in a rapid review on the impact of COVID-19 on people with disabilities (Meaney-Davis, Lee, & Corby, 2020). Such lack of access to information on prevention and transmission, as Kuper et al. (2020) and Mulibana (2020) put it, may subject people with disabilities to a higher risk of contracting COVID-19. For instance, people who are deaf often face medical challenges due to unavailability of sign language interpreters in hospitals and as a result of service providers not knowing or understanding sign language (Huisman, 2020). Not all national televised broadcasts relating to COVID-19 information on transmission, prevention or statistics had sub-titles, which resulted in many people with hearing impairments being excluded (McKinney et al., 2020). In addition, not being able to lip-read service providers, due to the compulsory wearing of marks, and low levels of literacy among many people who are deaf, resulted in additional communication challenges (Andrade & Baloyi, 2011; Glaser & Van Pletzen, 2012).

5. Additionally, **access to water, sanitation and hygiene facilities remains disproportionate for some people with disabilities**, compared to people without disabilities (Department of the Presidency [DoP], 2020; UN, 2018). While efforts from the Department of Water and Sanitation to ensure water provision through the distribution of water tanks are duly noted, not all people with disabilities may have been reached, due to South Africa’s poor infrastructure and spatial
challenges. This is particularly concerning, given that the majority of people with disabilities, especially in rural and informal dwelling settings, live in homes with no running water, taps that are inaccessible to those with certain disabilities, and rivers that are situated far from residential areas and oftentimes risky for people with disabilities (Grut et al., 2012), thus making frequent handwashing difficult (McKinney et al., 2020). More importantly, this may have an impact on sanitation practices, which are central to containing the spread of the pandemic.

6. Social distancing and isolation may be unrealistic for some people with disabilities who live in residential institutions or who are dependent on personal assistants or carers. It is well established that in institutions, such as homes for the aged or care facilities for people with disabilities, where people live in close proximity to one another, there is a high risk of substantial virus outbreaks (DoP 2020; Meaney-Davis et al., 2020; Minkowitz, 2020). Additionally, some people with disabilities, such as those with visual impairments, rely on touching surfaces to navigate everyday activities, such as reading Braille and using shared assistive devices. In the context of self-isolation and social distancing, these may present survival challenges. For example, some wheelchair users require close-proximity care from others for feeding, positioning, washing, getting in and out of bed, and other kinds of personal assistance. Without this personal care, some may not be able to function or survive. People with mobility devices, such as crutches and walkers, who live in institutions of care, might not have access to the sanitising equipment required to sanitise their devices, or they may not be physically able to do this themselves (McKinney et al., 2020; WHO, 2020). This shows that many prevention and treatment measures undertaken to reduce transmission of COVID-19 may not be adequately inclusive of people with disabilities (WHO, 2020).

7. The above issues may collectively evoke fears and anxieties among people with disabilities, not only regarding contracting COVID-19, but equally due to the implications of potential isolation and negative economic impacts (Armitage & Nellums, 2020). As such, mental health conditions may become prevalent among people with disabilities as a result of COVID-19 and pre-existing mental health conditions and psychosocial disabilities may deteriorate. The pandemic has resulted in a complete change to the psychosocial environment, including isolation and contact restrictions, which have the potential to negatively impact on the mental health of many people with disabilities (Fegert, Vitiello, Plener & Clemens, 2020; Patel, 2020).

8. Lastly, COVID-19 may exacerbate the cycle of poverty and disability as a secondary impact. Some of the long-term effects of COVID-19 include loss of work, lack of income and increased
hunger, in addition to lower rates of sustainable livelihoods (DoP, 2020), as well as the increased likelihood of impairments associated to related infections and/or co-morbidities. While there was a stimulus package provided by the South African government, a Statistics South Africa (2020) online study revealed that many people with disabilities did not receive food parcels. There is, therefore, a likelihood that people with disabilities may remain poor in respective contexts, leading to a burden of perpetual inequality and poverty (Hanass-Hancock & Mitra, 2016). This suggests that, without addressing disability inclusion, people with disabilities are exposed to more health risks, which increase their susceptibility to contracting COVID-19 (Sherry, 2015), and they remain subjugated to poverty and inequality (Hanass-Hancock & McKenzie, 2017). This is particularly concerning within the South African context, where prevailing social protection mechanisms do not necessarily take cognisance of the economic impact of diverse conditions, types and severity of impairments and the extra costs related to disability (Hanass-Hancock & McKenzie, 2017). The need for support may thus be higher post-COVID-19, given the higher vulnerability of people with disabilities.

As our themes were deductively selected, based on this rapid review, we do not claim that these issues are exhaustive. There are a range of additional issues affecting the lives of people with disabilities during this COVID-19 outbreak, but we could not elaborate on this, in this paper.

**CHALLENGES OF DISABILITY DATA AND THE NEED FOR FURTHER RESEARCH**

South Africa currently experiences a significant under-reporting of challenges related to disability – to date, there is no disaggregated data for disability and COVID-19 (Loeb, Eide, Jelsma, Toni, & Maart, 2008; Sherry, 2015). The current recording system does not indicate how many cases represent people with disabilities. Neither is it recorded who develops complications leading to impairments associated with co-morbidities. It may be that future planning for resources will thus exclude people with disabilities, due to this lack of data, as, often, what is not counted does not count. It is therefore critical to collect data on disability within the COVID-19 response. A disability measure could be included in data collection to facilitate the tracking of vulnerability of people with disabilities to contracting the virus, becoming critically ill or dying, compared to those without disabilities, using the Washington Group set of survey questions (Madans, Loeb, & Altman, 2011; Washington Group on Disability, 2020).
Additionally, more research is needed on COVID-19 and disability (McKinney et al., 2020; Sabatello, Burke, McDonald & Appelbaum, 2020). The authors are currently collaborating on and conducting a study to understand the effects of COVID-19 on the lives of people with disabilities. Our study is focusing on health-related access issues, livelihood and educational issues, anxiety and mental health or life and death issues, which may be facing people with disabilities as well as perspectives about the rationing of resources as they relate to disability. We are also documenting experiences, additional needs and suggested solutions, which may assist in ensuring that COVID-19 responses are appropriately tailored and used to enhance inclusive policy, planning and practice. These results will be published at the conclusion of the data analysis process.

CONCLUSION

The issues highlighted above demonstrate the multidimensional risks facing people with disabilities and emphasise that focused attention must be paid to their rights, which are at risk of violation. While both inaccessible healthcare systems and the presence of underlying health conditions put people with disabilities at additional risk, vulnerability to severe illness and death, post-contracting COVID-19, this vulnerability is exacerbated by the interaction between impairments and personal and environmental barriers at different levels, resulting in a disproportionate impact for people with disabilities. This suggests that it is not sufficient to look only at underlying medical conditions as an indicator of risk for contracting COVID-19. Rather, contextual factors, including attitudinal, environmental and institutional barriers, together with prevailing systemic issues, need specific investigation.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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Governments’ Responses to the Coronavirus Pandemic clears the Road for their Responses to the Traffic Pandemic

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ABSTRACT
Governments all over the world have been instrumental in limiting the devastating effects of the highly infectious COVID-19 pandemic. Although the success rate of a plethora of completely novel legislations is still yet unknown, there can be little doubt about the intensity of political will and resources allocated to fight the spread and effects of the pandemic. In this perspective piece, a comparison is made between governmental responses worldwide to COVID-19 and their responses to a much longer-lasting and even more devastating pandemic, the catastrophe of road traffic crashes. Comparing these two pandemics highlights the negligible level of attention road traffic crash prevention has received in the past and the valuable lessons that can be drawn for the future.

Keywords: Disability, COVID-19, inclusion, South Africa, healthcare

Never let a good crisis go to waste.
- Marcus Aurelius

THE CORONAVIRUS PANDEMIC

Towards the end of 2019, the Chinese Government became aware of a number of cases of viral pneumonia of unknown origin and subsequently began investigating these in early January 2020. Initially, the cases seemed to be linked, pointing to the origin of the virus concerned being in the Huanan Seafood Wholesale Market. The virus was suspected to have an animal origin and has since been linked to certain bat and pangolin coronaviruses, as well as to Severe Acute Respiratory Syndrome (SARS) (Huang et al., 2019; World Health Organisation [WHO], 2020a). (See Figure 1).
Over a period of a few months, this virus (now identified as a coronavirus – COVID-19) expanded into a global pandemic, causing severe acute respiratory syndrome in its victims, some of whom required mechanical ventilation. On 30 January 2020, the World Health Organization declared the outbreak to be a Public Health Emergency and, on 11 March 2020, announced that the disease was a global pandemic (WHO, 2020b; WHO 2020c). As at 24 July 2020, more than 15 million cases of COVID-19 had been reported in 185 countries, resulting in more than 600,000 deaths. The spread of the pandemic has been fast and devastating, with certain countries much worse affected than others (European Centre for Disease Prevention and Control, 2020) (See Figure 2).

Figure 1: The Coronavirus.

Figure 2: The spread of COVID-19 Cases per 100,000 population per country (European Centre for Disease Prevention and Control. Retrieved 21 May 2020).
The virus is primarily spread between people during close contact, often via small droplets produced by coughing, sneezing, or talking (Bourouiba, 2020; Centers for Disease Control and Prevention, 2020). While these droplets are produced as carriers breathe out, they usually fall to the ground or onto surfaces rather than remaining in the air and travelling over long distances. Recommended preventive measures include:

- **Hand washing**
- **Covering one's mouth when coughing**
- **Maintaining distance from other people**, and
- **Monitoring and self-isolation for people who suspect that they are infected.**

Authorities worldwide have responded rapidly (some more promptly than others) by implementing:

- **Travel restrictions**
- **Quarantines**
- **Curfews**
- **Stay-at-home orders,**
- **Workplace hazard controls, and**
- **Facility closures**

Many places have also worked to increase testing capacity and to trace the contacts of infected persons. The pandemic has led to severe global socioeconomic disruption, the postponement or cancellation of sporting, religious, political and cultural events, and widespread shortages of supplies – the last-mentioned exacerbated by panic buying. The pandemic has led to one of the largest global recessions in history, with more than 3.9 billion people — more than half the world's population — under some form of lockdown by the first week of April (Euronews, 2020; Jones, 2020). Schools, universities and colleges have closed, either on a nationwide or local basis, in 197 countries, affecting approximately 99.9 per cent of the world's student population. The scale of the Corona pandemic is astonishing in its own right, but in order to assess its impact we compare it here to another pandemic, that of road traffic crashes.

**THE CORONAVIRUS PANDEMIC IN PERSPECTIVE VERSUS ROAD TRAFFIC CRASHES**

The world has grown insensitive towards the enormous number of people who suffer injuries in road traffic crashes. According to the World Health Organization, over 1.4 million people lose their lives
each year as a result of such crashes (Abubakar, Tillmann, & Banerjee, 2015). In addition, over 50 million people suffer non-fatal injuries and many incur permanent disabilities (Global Burden of Disease Study, 2014). Young people (between the ages of five and 30 years old) carry by far the highest risk in this regard. In addition, ninety per cent (90%) of deaths occur in low and middle-income countries, with road traffic injury death rates being the highest in the African region. The causes of road traffic crashes have been identified as either (1) the Driver; (2) the Vehicle; or (3) the Road infrastructure. Reports from all over the globe, however, provide evidence that drivers contribute by far the largest proportion (80–90%) of these deaths.

There have been numerous recommendations by the WHO to curb this massive onslaught on human health (Peden et al., 2004):

- **Speeding**
  - Speed is directly associated with the severity of a crash. For example, every 1% increase in mean speed produces a 4% increase in crash fatality risk, and a 3% increase in the risk of a serious crash occurring. The risk of death for a pedestrian hit by a car rises rapidly with vehicle speed (4.5 times greater from 50 km/h to 65 km/h).

**DRIVING UNDER THE INFLUENCE OF ALCOHOL AND OTHER PSYCHOACTIVE SUBSTANCES**

Driving under the influence of alcohol and any other psychoactive substance or drug increases the risk of a crash that will result in death or serious injury. In the case of drink-driving, increased risk of a road traffic crash starts at low levels of blood alcohol concentration (BAC) and increases significantly when the driver's BAC is $\geq 0.04$ g/dl.

**NON-USE OF SAFETY MEASURES SUCH AS MOTORCYCLE HELMETS, SEATBELTS, AND CHILD RESTRAINTS**

For motorcyclists, correct helmet use can lead to a 42% reduction in the risk of fatal injuries and a 69% reduction in the risk of head injuries. Wearing a seatbelt reduces the risk of death among drivers and front seat occupants by 45–50%, and the risk of death and serious injuries among rear seat occupants by 25%. The use of child restraints can lead to a 60% reduction in deaths.
DRIVER DISTRACTION

There are many types of distractions that can lead to impaired driving and the level of distraction caused by mobile phones in particular is a growing concern for road safety. Drivers using mobile phones are approximately four times more likely to be involved in a crash than drivers not using a mobile phone. Using a phone while driving slows reaction times (notably braking reaction time and also reaction to traffic signals) and makes it difficult for the driver to remain in the correct lane and to keep the correct following distances. Hands-free phones are not much safer than hand-held phone sets, and texting considerably increases the risk of a crash.

In summary, very effective strategies have been identified but, unfortunately, in spite of the vast scope of scientific research on the pandemic of Road Traffic Crashes (which, in the past has been referred to as “Carmageddon”) and its massive impact on global health and the world economy, local, regional and national echelons of government have been extremely sluggish as regards appropriately implementing effective measures and promoting road safety. Children remain vulnerable and their rights have been, and continue to be significantly violated, since they are exposed daily to unacceptable levels of environmental dangers. By its Judging by the absence of the issue from the broader political agenda, road traffic deaths appear to have been marginalised by politicians and other social actors globally.

WHAT CAN WE LEARN FROM THE CORONAVIRUS PANDEMIC TO REDUCE THE ROAD TRAFFIC CRASH PANDEMIC?

The Coronavirus Pandemic has been thrust into the very centre of everyone’s attention since the beginning of 2020 and the response by governments around the globe has been unprecedented. Extensive media coverage has been produced and far-ranging lockdowns have been implemented by governments along with widespread advocacy for the mandatory use of Personal Protection Equipment (PPE) by all frontline workers. The general public, primed with fear and precautions, have been quick to adopt a wide range of behavioural changes, the wearing of face masks in numerous countries in particular. It is interesting to note that some of the measures implemented (such as wearing various types of face-masks and social distancing) have not been sufficiently scientifically researched so as to be proven effective.
The challenge for health policymakers is to capitalise on the learning that has taken place as well as the effects of this phenomenon and to adapt and contextualise it to promote behavioural changes among road users.

Driver behaviour remains the key impediment to any progress in bringing down road traffic crash numbers. Unlike with the Coronavirus, infection with which may, at some stage, be preventable with a vaccine, the problem of road traffic crashes cannot be controlled by introducing a vaccine-like technology. In the same way that the Coronavirus can be prevented from spreading by paying heed to behavioural safety guidelines, reducing road traffic crash numbers will also require the adoption of safety-oriented behaviour. Strategies directed at behavioural changes have been shown to be successful in reducing both injury-risk behaviours and injury outcomes (Sleet, Hollenbach, & Hovell, 1986). It is interesting that, in several countries where an alcohol-ban was introduced as one of the strategies to fight the spread of the Coronavirus, a decrease in the number of road traffic crash fatalities has been noted, although the exact effects of the alcohol ban on road traffic fatalities still requires scientific research. The most successful strategies to reduce road traffic crashes have been planned and implemented with applied behaviour analysis. This methodology uses contingency management through various forms of rewards and incentives, behavioural shaping, and modifying environmental cues and conditions to affect not only driver behaviour, but also that of occupants and even pedestrians. At the societal level, laws and enforcement strategies that discourage or punish risky behaviours are a form of contingency management.

Behavioural modelling, demonstration, and skill building, can all be used to modify risky behaviours, particularly among young people, in order to address the recommendations made above in respect of decreasing the major risk factors (Fylan & Stradling, 2014). Social support, feedback, reinforcement, and the real threat of punishment should all be used to modify problematic behaviour. Application of these strategies, and others that rely on legislative and enforcement strategies to change behaviours, has been found to be effective (Sleet et al., 1986). Road safety is a result of safe behaviour by all road participants, including those responsible for road design and the maintenance of the road networks, and, most importantly, governments who must support stringent research, surveillance, monitoring and evaluation, as well as implement and enforce policy. There is no doubt that political will, and changing traffic and pedestrian behaviour globally, holds promise for the future.
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SUBMISSION GUIDELINES

Social and Health Sciences (SaHS), previously African Safety Promotion: A Journal of Injury and Violence Prevention (ASP) is published twice a year. Submissions within the following guidelines are welcome. Please submit your contributions or queries to the Editor-in-Chief, Social and Health Sciences, at Institute for Social and Health Sciences, University of South Africa, P. O. Box 1087 Lenasia, 1820, South Africa, or via e-mail to ismaig@unisa.ac.za or sahs@unisa.ac.za. Scientific contributions are to be prepared and submitted as indicated below.

MANUSCRIPT PREPARATION

The manuscript must be accompanied by a letter indicating that the article has not been published elsewhere. This letter must be signed by all listed authors to indicate their agreement with the submission. All manuscripts should be typed in 1.5 spacing with a margin of 3.5 cm on the left and right sides of the page. The manuscripts should be in 12-point Times New Roman font, with the main headings in capitals and bold, and sub-headings in capitals. No enumerations and section numbering should be included, and all graphs and tables should be inserted at the end of the document. There are five categories of submissions accepted for publication in ASP, as detailed below.

ORIGINAL CONTRIBUTIONS

Criteria for manuscripts submitted under this category have been revised and include changes to word length as well as a new subcategory for qualitative research or studies using ‘mixed methods’ (combining qualitative and quantitative research methods). Revised criteria are as follows:

a) Full scientific manuscripts following quantitative research methods should not exceed 5 000 words in length excluding the title, abstract, references, figures and tables.

b) Manuscripts following qualitative, or a combination of quantitative and qualitative research methods should not exceed 6 000 words in length excluding the title, abstract, references, and tables.

LITERATURE REVIEWS

Manuscripts submitted as a literature review should not exceed 6 000 words excluding the title, abstract, references, and tables.

BOOK REVIEWS

Copies of books may be sent to the Editor-in-Chief.

PERSPECTIVES

These communications include commentaries on events in the injury prevention sector, and organisation or programme reports. These should not exceed 2 500 words, excluding references. Perspectives should offer informed, critical commentary on especially emerging theoretical,
research, programmatic or policy issues in the injury prevention, safety and peace promotion sectors. There should be some theoretical or research basis for the interrogation of these conceptual, research or policy issues and the perspective conclusions should have clear relevance for the prevention domain.

All original contributions should have the following sections:

- **Title Page:** This page should include the title of the manuscript, all authors and their affiliations. Full contact details should be included for the corresponding author. The category in which the manuscript is to be submitted should be indicated at the top of the page.

- **Abstract:** All manuscripts, except perspectives and book reviews, should include an abstract placed before the main text of the article. This abstract should not exceed 250 words in length. Abstracts must be accompanied by a minimum of 5 keywords. While all abstracts need to be submitted in English, authors are also allowed to submit translations of these abstracts in French or Swahili.

- **Main Text:** The main text of the article should, as far as is appropriate, be divided into the following sections: Introduction, Methods, Results, Discussion, and Prevention Implications.

**STYLE AND REFERENCES**


Please note the format for the Reference List. For example:


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PLAGIARISM

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