

South Africa must adopt a localised response to COVID-19. What it would look like

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South Africa needs to adopt a more localised and differentiated approach in the next phase of its management of the COVID-19

pandemic.

This might not be as difficult as it seems at first glance. Firstly, some of groundwork has already been done. The minister of health outlined a classification of districts in terms of [three categories](#). These were: areas of "vigilance" (fewer than five cases per 100,000 people); emerging hotspots (fewer than five cases per 100,000 people, but rapid rise in infections); and hotspots (more than five cases per 100,000 people), with periodic reviews of area classifications. It seems that hotspots will be the focus for increased attention as the country progressively eases up on restrictions.

Another reason South Africa's localised response will be made a little easier is that the country has extensive lessons to draw from three decades of managing HIV/AIDS. As with HIV, COVID-19 infections are currently [clustered](#) within certain geographical areas and pose greater risk for [particular populations](#).

For a localised approach to work, however, five crucial steps need to be taken. These range from intensified screening and testing in hotspot areas to focused attention on high risk transmission sites and adjusting to local cycles of restrictions.

In addition, this risk-adjusted approach to COVID-19 will require local participation and a multi-sectoral response.

This strategy is not a "magic bullet solution" to managing COVID-19. But its potential effectiveness lies in promoting greater social and political solidarity that is grounded in the realities of people's lives, where people will find it easier to collectively develop workable solutions.

Five key ingredients

Key activities are required for an effective localised COVID-19 management response, based on the following interventions.

The first is intensified screening and testing in hotspot areas. Spreading limited COVID-19 [screening and testing](#) nationally will place strain on the health workforce. This therefore requires intensifying screening and testing in the hardest hit districts. This was a key component of managing the HIV pandemic.

COVID-19 testing could be scaled up using the GeneXpert platform—currently used to diagnose tuberculosis (TB). South Africa was the first country to roll out the platform. This method has the advantage of being rolled out in mobile laboratories. For the moment, however, there's a shortage of cartridges.

Secondly, urgent steps need to be taken to locate and screen high risk and vulnerable people.

Epidemiologists [predict](#) that COVID-19 cases will peak in July or August. Vulnerable populations include people older than 55 years, those with existing co-morbidities and poor and marginalised people. For the latter, living arrangements and lack of water and sanitation make it difficult for them to practise physical distancing and wash their hands.

Here, the services built for HIV and TB could be mobilised. These includesurveillance systems to trace and screen people.

Thirdly, focused attention is needed on high risk transmission sites. These include provincial borders, main transport routes, country borders, taxi ranks, truck stops, shopping centres, work places, retail services and schools.

And rapid testing is recommended for people moving between high and

low infection areas.

As has already begun to happen, infection levels should inform decisions on opening of businesses, health services and schools. Schools or workplaces may have to be assessed as a "community" within a community with a differentiated approach depending on COVID-19 prevalence and local health system capacity to respond.

Fourthly, there needs to be a scaling up of serological testing. The current polymerase chain reaction based testing is reliable for diagnosing active cases. But it must be paired with reliable antibody based serological testing.

Antibody tests could identify individuals who have been infected as well as those who have recovered from infection, therefore indicating better estimates of COVID-19 prevalence. Equally important, serological testing would provide demographic profiles and recovery rates. It would geo-locate the areas where a high proportion of individuals with antibodies are.

These tests can be done by nurses at a clinic or hospital. They are usually much cheaper than lab tests and give results in less than 20 minutes. But they have a shortcoming; they test for antibodies, not the virus directly, so a person who has been infected and recovered will [test](#) positive.

The science of antibody based serological testing is still evolving. There are still unanswered questions. For example: how long after exposure and infection do antibodies develop? Are antibodies likely to be protective from repeated exposures? Is the sensitivity and specificity of antibody tests effective enough to minimise misclassification of COVID-19 infection?

The phased application of these tests with repeat large scale surveys, as

we have seen with HIV surveillance surveys, would provide a better picture of the evolving epidemic. It would help improve decision-making about infection control in communities and afford greater protection in areas where there is a concentration of [vulnerable people](#).

Finally, the country needs to adjust to local cycles of restrictions and release. With no vaccine or effective treatment yet for COVID-19, communities in different parts of the country are likely to move between levels of lockdowns, either escalated or de-escalated, informed by COVID-19 infection rates.

The shifting and revolving approach to restrictions and release will no doubt cause disruptions to the economy, straining health and social care systems and creating major social anxieties within communities. Therefore, clear messaging from government is required on the rationale for restrictions being implemented at the district level.

Way forward

The lived realities of COVID-19 will differ according to place and context. This will entail multiple and different trade-offs for South Africans.

A localised response therefore should facilitate conversations between different constituencies. Here too the country can draw on lessons in managing the HIV/AIDS pandemic. This provided examples of community based strategies to manage a pandemic by promoting social capital, trust and local leadership to enable [behaviour changes](#) that protected health.

There is no exit strategy for COVID-19 in the foreseeable future. A localised response that builds on social forms of agency should be the way forward.

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