SOUTH AFRICA’S SOCIAL DEVELOPMENT SECTOR RESPONSE TO COVID-19

Updated 14 April 2020

In the coming weeks, South African policymakers will continue to make critical decisions to curb the spread of COVID-19 and reduce its economic impact. In collaboration with the National Development Agency, IDinsight prepared a brief to inform decision-making in two areas of interest for the Department of Social Development: 1) promoting healthy community behaviors, and 2) providing social protection to vulnerable populations.

CONTEXT

Since the first case of COVID-19 was confirmed in South Africa on 5 March 2020,1 the national government has taken steps to minimize the spread and impact of the virus. On 23 March 2020, nine days after detection of the first locally transmitted case,2 President Cyril Ramaphosa announced a nationwide 21-day lockdown.3 On 9 April 2020, the President extended the lockdown for another two weeks4. Despite rapid, decisive action from the Government of South Africa, COVID-19 still poses a significant threat to the country as both:

- A **highly contagious public health risk** amplified by a large population with high prevalence of co-morbidity factors5 (many patients with HIV and out-of-treatment,6 tuberculosis,7 and other previous conditions), crowded living conditions in informal settlements,8 and a healthcare system unlikely to cope with an increased influx of patients (186 hospital beds per 100,000 population).9
- An **economic risk**, disproportionately impacting low-income and vulnerable populations10.

To **minimize the spread of the virus** and **support vulnerable populations**, policymakers must continue to deploy public health and social protection policies in parallel and in a coordinated fashion, leveraging partnerships with the civil society. A data-driven approach will help ensure that policies are 1) effective for the target populations and 2) responsive to the country’s evolving needs.

The objective of this policy brief is to inform the Government of South Africa’s COVID-19 policy design by:

1. **Suggesting approaches to leverage data to strengthen the pandemic response (Section A);**
2. **Sharing policy lessons from relevant contexts to:**
   a. **promote healthy community behaviors**
   b. **provide social protection to vulnerable populations (Section B)**
3. **Providing a simple decision-making framework to evaluate potential policy responses (Section C).**
SECTION A: LEVERAGE EXISTING DATA AND REMOTE DATA COLLECTION TO INFORM THE RESPONSE

Data-based decision-making is particularly important given the uncertain and fast-moving nature of the pandemic. Beyond critical information on outbreaks of the virus and infected populations, data can provide a real-time snapshot on the state of program or policy implementation, the behavior of specific groups, and knowledge or attitudes on COVID-19. This data can be immediately analyzed to derive insights to improve the effectiveness and appropriateness of the government’s response.

BOX 1. TRANSFORMING DATA INTO IMPACT

In our experience, data and measurement are best positioned to achieve impact via program and policy decisions when they are:

- **Demand-driven and actionable** – Measurement and evaluation activities should be undertaken when a stakeholder desires actionable data to inform a specific decision. Data efforts should aspire to quickly and frequently meet decision-maker needs to establish a virtuous data demand (and usage) – data generation cycle.

- **Technically, practically, and culturally sound** – all three of these dimensions need to be effectively addressed. Technical (e.g. precision, accuracy, representativeness, comprehensiveness), practical (e.g. time, budget, operations, capacity), and cultural (e.g. politics, history, enthusiasm, trust, incentives) all interact.

- **Lean** – Most countries are characterized by limited data demand, low quality data supply, and significant data system fatigue. In such an environment, lean approaches and quick wins are paramount to kindle the foundational fire required for longer and larger efforts to succeed.

We recommend following the next steps to materialize the above principles:

**Step 1. Establishing decision-making priorities and evidence gaps.** What evidence/measurement is needed to set the policy up for success/make critical decisions? What stage is the policy/program at? What critical decision-making information we do not yet? This step typically includes developing a preliminary Theory of Change - a visual narrative diagram that defines how the activities under those programs ultimately can lead to the desired outcomes.

**Step 2. Understanding the constrains.** What are the time, budget, operational, and political factors constraining decision-making, evidence generation, and measurement possibilities?

**Step 3. Developing Measurement/Analytical Menu.** Listing measurement and/or evidence-generating options with non-technical commentary on the technical rigor, time, cost, and operational implications for each option.

**Step 4. Choosing the most appropriate tool.** There is no intrinsically superior measurement tool; choosing the most appropriate tool will depend on the previous steps. Please see Appendix 1 for an illustration of frequently used measurement tools and their typical function.

**Step 5. Generating a recommendation, making a decision, and establishing new steps/decision-making needs.** Measurement should always be translated into a decision. Frequently, new evidence will engender new questions and needs for investigation.
There are four steps that form the data-driven decision-making framework (Figure 1). High-quality data coupled with succinct analysis and presentation can best inform decisions about which policies to implement when. While in-person data collection approaches may not be feasible during the pandemic, alternative options exist to inform critical COVID-19 policies (see Table 1).

**Figure 1. Data demand and supply cycle**

![Data demand and supply cycle diagram](image)

**Phone-based surveys and administrative data** can be used to rapidly gather critical information, especially from hard-to-reach, low-income populations. For example, **IDinsight leveraged phone surveys to conduct a rapid survey** to gather critical data on COVID-19 related knowledge and attitudes, social distancing practices, and economic impacts of the lockdown in India. This exercise was conducted in only five days.

**Table 1: Examples of using data to inform COVID-19 policies**

<table>
<thead>
<tr>
<th>Decision(s)</th>
<th>Data</th>
<th>Mode of data collection</th>
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<tbody>
<tr>
<td>• Directing resources to increase healthcare system capacity</td>
<td>Data on geographical distribution of COVID cases and the corresponding number of tests performed, local hospital capacity</td>
<td>Existing monitoring/communication system in health system</td>
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<tr>
<td>• Designing interventions/preventative measures based on knowledge, attitude and practice (behavioral change communications campaigns’ effect on social distancing, hand washing, etc.)</td>
<td>Data on geographical distribution of vulnerable populations at high risk of severe illness due to COVID</td>
<td>Existing data (e.g. Gauteng City-Region Observatory datasets)</td>
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<tr>
<td>• Identify optimal unit(s) for social distancing</td>
<td>Data on people’s knowledge, attitude and practice related to COVID and preventative measures (e.g. social distancing) including misinformation</td>
<td>Phone survey</td>
</tr>
<tr>
<td>• Targeting cash and in-kind assistance; provision of hand washing facilities</td>
<td>Data on geographical distribution of poverty and informality</td>
<td>Existing data (e.g. Gauteng City-Region Observatory datasets)</td>
</tr>
<tr>
<td></td>
<td>Data on the economic impact of the pandemic, e.g.</td>
<td>Phone survey</td>
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unemployment, food shortages or increase in food prices

• Allocation of medical resources

<table>
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<td>Social and behavioral change communication</td>
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<td>How to engage civil society in promoting community healthy behaviors?</td>
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B. RELEVANT LESSONS FOR SOUTH AFRICA’S RESPONSE

1. PROMOTE HEALTHY COMMUNITY BEHAVIORS

Absent an effective vaccine or treatment, behavior change activities are critical to preventing the spread and reducing stress on the health system. We describe behavior change health interventions below to mitigate the effects of COVID-19. We also provide specific strategies to leverage South African civil society to build trust and facilitate behavior change. Please note we do not cover core public health policies/guidance, which have been extensively covered in many other reports.

See Table 2 below for a summary of measures to consider.

Table 2: Summary of measures to consider to promote healthy community behaviors

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1.1 TAILOR “SOCIAL DISTANCING” TO TOWNSHIPS AND INFORMAL SETTLEMENTS

“Social distancing” is a key measure to prevent the spread of COVID-19. South Africa has imposed stringent social distancing measures through the nationwide lockdown announced on 23 March 2020 and extended on 9 April 2020. Yet in townships or informal settlements, extreme social distancing is a luxury that low income populations struggle to afford. Predictive models have suggested that not only are the epidemiological and economic benefits of lockdowns and stay-at-home policies much smaller in poorer countries, such policies may also exact a heavy toll on the poorest and most vulnerable.

According to 2016 data, only 44.4 percent of South Africans had access to water inside their dwelling, and only 60.6 percent to a flush toilet connected to the sewage system. At least four million people — 15 percent of the population — live in densely populated, informal urban settlements with communal taps and toilets. Further, People living in townships already live alongside serious infectious diseases like Tuberculosis. As a result, it is important to recognize that staying home may itself be a risk for many residents in informal settlements.

LESSONS FROM OTHER CONTEXTS

The stark spatial inequality of South Africa presents a unique challenge for public health officials. Public health strategies that may have worked well in East Asia and Europe would need to be adjusted for the townships and informal settlements where 5.4 million South Africans live. For example, while in Europe and East Asia, the predominant cohort unit is the household, in South African informal settlements it might encompass a compound, a street, a block or even a district.

CONSIDERATIONS FOR SOCIAL DISTANCING IN TOWNSHIPS AND INFORMAL SETTLEMENTS

While South Africa’s early lockdown has bought valuable time to reinforce the country’s health system and testing capacity, the lockdown is likely not sustainable in the long-term due to the economic and social disruptions exacerbated by inequality. Despite limited research, there is some indication that the following efforts could be effective to inform policy approaches in informal settlements:

1. Encourage social distancing for community ‘units’ rather than individuals: Even if mass self-isolation is infeasible in townships, policymakers could consider self-containment of cohorts of people (the smallest possible unit that can provide each member with essential provisions and services) to slow transmission:
   a. Policymakers could recommend the creation of rotating systems for essential tasks such as going to the market, fetching water, or collecting mobile payments. If one member of the cohort is infected, officials can quarantine the entire cohort unit to achieve a similar result to contact tracing.
b. Policymakers should consider a potential trade-off between reducing infection outside the unit and those in the unit getting infected (for example by the one person doing essential tasks).

c. Policymakers should consider the costs of social distancing measures with respect to non-COVID-19 healthcare services and supply chains like vaccination, insulin, antihypertensives, and reproductive, maternal, and child health. Stringent social distancing measures may disrupt the continuity of established treatment regimens for key chronic diseases, resulting in higher net mortality.

2. **Provide guidance for semi-formal and informal businesses to facilitate social distancing:** Semi-formal and informal businesses form the majority of all businesses in townships. Policymakers should put in place clear social distancing guidelines for these businesses. For example, in open-air stores, vendors can use objects or draw lines to indicate how people should line up to encourage social distancing.

3. **Identify vulnerable populations and provide clear guidelines for households to help protect the most vulnerable:** Within households, social distancing measures should focus on three pillars: limiting contact with those outside the dwelling, context-specific hygiene recommendations, and protecting vulnerable household members. Collecting health data with greater precision will allow policymakers to identify vulnerable individuals within household groups and/or social distancing units (see Section A). For example, high-resolution health data can enable specific social isolation guidelines to be issued to households with immunocompromised members. Further, policymakers could consider enacting specific quarantine rules, for example not sharing food or sleeping in the same bed, for migrants upon their return.

4. **Identify local barriers to or enablers of public health measures:** Policymakers could consider which local practices support positive health outcomes and which might make social distancing or other measures more difficult. Such enablers of and barriers to public health might include a population’s awareness of the severity of COVID-19 or the risk of asymptomatic carriers. Access to soap and water should be prioritized if it is identified as a barrier in a given community. Other barriers/enablers might be behavioral or cultural and specific to each context.

### 1.2 SOCIAL AND BEHAVIORAL CHANGE COMMUNICATION

Given the novelty of COVID-19, social and behavioral change communication should play a central role in containing the spread of the disease. People may neglect preventive measures/healthy actions because they do not have access to (or the bandwidth to pay attention to) relevant new information; or they may be dissuaded from pursuing other options because they may have culturally absorbed mental constructs that discourage them.

Research on best practices in health communication has shown that social and behavior change communication is most effective when:

- It is data-driven, guided by social and behavioral theory, and rooted in addressing local barriers to or enablers of public health measures
- It focuses on multiple levels of change: individual, family, community and social – in an enabling environment
- It is combined with improvements in health service delivery
- It creates community engagement through participatory approaches
- It uses a mix of media and a combination of communication approaches, including new media technologies

When possible, communication activities should be two-way – both the government/other organizations communicating to the people, but also the people communicating to the government/other organizations. This can be in the form of community dialogues, workshops, interactive SMS-based messaging, or other approaches that enable people to ask questions and engage with the information. The government can build upon existing platforms such as HealthAlert, an interactive COVID-19 WhatsApp support line launched by Praekelt on 20 March 2020.

LESSONS FROM OTHER CONTEXTS

During the 2014 Ebola crisis, mobile social media campaigns were implemented in Liberia and Nigeria to provide public health messaging. While the use of social media significantly reduced the spread of Ebola in Nigeria by 75%, it was not as effective in reducing the spread in Liberia because of the persistence of misinformation and the mistrust of government messages. Furthermore, implications of the Ebola virus disease outbreak in Guinea found that ineffective communications at multiple levels not only contributed to heightened feelings of confusion, stigma, and fears, but also exacerbated existing levels of distrust and skepticism among the local community toward the medical community and the government.

CONSIDERATIONS FOR EFFECTIVE BEHAVIORAL CHANGE COMMUNICATIONS

1. **Messages should be simple and concise and illustrate the repercussions of no action.** Simple and “rule of thumb” messages work better. Consider including those who are illiterate or speak mother-tongue languages. Insights from behavioral science tell us that messages should be candid, emphasizing the consequences of noncompliance. Minimizing the danger can undermine the credibility of officials, eroding the effectiveness of future communications.

2. **The message must be consistent across sources,** signaling it is to be trusted. For example, developing consistently formatted information materials with the official government stamp will help individuals determine the validity of the information.

3. **Messages should be tested with a sample of respondents** before they are scaled-up. A wrongly interpreted message can erode trust, create confusion, and waste resources. As messages will need to be crafted in different languages, or with pictograms, it is critical to ensure that they can be understood by target audiences. Testing their effectiveness, even with a small sample, before scaling can help ensure they are interpreted as intended.

4. **Messages should also be relayed through multiple channels of communication.** Trusted messengers and enforcers within the community can lend legitimacy to calls for frequent hand-washing, exercising cough etiquette and social distancing.

5. **Communications activities need to be complemented by initiatives** (e.g. providing soaps/sanitizers, installing handwashing facilities in all public places) that make it easy for the public to comply and address the barriers to healthy behavior.
Box 2. Considerations for Engaging Civil Society to Promote Healthy Community Behaviors

Organizing, mobilizing, resourcing, and deploying community-based organizations to act as frontline advocates for behavior change is critical to the effective implementation of social distancing and other healthy behaviors in informal settlements. Community-based organizations with longstanding roots in townships are uniquely positioned to understand local population needs and facilitate the development of measures tailored to local constraints.

Lessons from other contexts

A study on Ebola response in Liberia found that those with lower trust in government (even when equally knowledgeable about transmission and symptoms) were less likely to comply with Ebola prevention measures. Those who experienced hardships such as job loss were also less likely to trust the government, and therefore less likely to comply. Experiences during the Ebola crisis in Liberia and Sierra Leone showed that civil society organizations cannot substitute for government institutions in the eyes of citizens. However, their understanding of community dynamics and local social norms can play a vital role in raising awareness, building trust, and mobilizing communities.

In South Africa, the constitution gives a special place for civil society to play an oversight role over democratic institutions, monitor human rights, and to giving citizens, especially the vulnerable, the tools to assert their rights. Civil society organizations have played a major role in shaping health policy in the country since the late 1990s, and continue to monitor public healthcare service delivery through an advocacy, legal and activist approach. With thousands of civil society organizations working with vulnerable populations, there is therefore potential for the government to leverage these existing trust links to drive behavior change.

Considerations to build community trust

1. Partner with civil society organizations to design and advocate for behavior change policies in response to COVID-19. Giving a voice to civil society organizations can illuminate communication gaps and promote accountability. Additionally, the government can create a network of civil society organizations and community-based organizations to facilitate coordination and enable rapid responses to community needs.

2. Partner with and consult trusted traditional leaders and respected figures including traditional chiefs, religious leaders, local public figures, famous artists, singers and nationally acclaimed athletes to create and disseminate messages so they are sensitive to local perspectives that might exacerbate or reduce the spread. These groups could also encourage and enforce positive health practices.

3. Government leaders should mirror the behaviors they expect of their citizens, e.g. respect social distancing during press conferences and other gatherings. In countries where leaders have not role modelled social distancing, people are hesitant to follow guidelines or fail to grasp the severity of the situation.
2. BOLSTER SOCIAL PROTECTION MEASURES FOR THE VULNERABLE

As of 10 April 2020, a total of 126 countries (including South Africa) have introduced or adapted social protection and jobs programs in response to the COVID-19 pandemic. On 25 March 2020, the Government of South Africa announced a suite of economic mitigation and relief measures, including an expansion of the Unemployment Insurance Fund (UIF) to provide paid sick leave and income support to affected workers, among others. In addition, the government created a Solidarity Fund to provide economic support for individuals, companies, and foundations. On 9 April 2020, the President announced that the Cabinet is actively developing a further package of urgent economic and social support measures in response to the crisis.

While these measures cushion the economic and social impact of COVID-19 in the short-term, more is likely required given the projected scale of economic contraction in South Africa. The rest of the section describes different social protection approaches and how non-government partners can support those (see Box 3). See Table 3 below for a summary of measures to consider.

**Table 3: Summary of measures to consider to bolster social protection**

<table>
<thead>
<tr>
<th>Approach</th>
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</table>
| Cash/in-kind transfers        | ● When possible, adopt and expand unconditional cash transfers to support the vulnerable  
                                  ● If cash cannot guarantee access to the essential food, supplement/unconditional cash transfers with supply and food distribution  
                                  ● Ensure safe pay/distribution points and/or use mobile payments  
                                  ● Leverage existing distribution networks where possible  
                                  ● Where possible, partner with public transportation lines that access hard-to-reach areas                                                                 |
| Modify existing social protection programs | ● Consider leveraging existing social protection programs:  
  ○ providing advance payments or lump payments together.  
  ○ simplifying administrative requirements  
  ○ plugging into other COVID-response schemes (e.g. supply or food distribution)  
  ○ expanding child support funds  
● Revaluate targeting to reach people most affected  
● Ensure that the method of disbursing benefits does not result in public health risks |
| Additional measures to combat domestic violence | ● Invest in public awareness campaigns  
● Services for survivors should be treated as essential  
● Establish referral linkages between health facilities and services available locally |
| Provide additional support to informal workers | ● Administrative and big data can be used to identify areas that have concentrations of informal workers or other vulnerable populations  
● Leverage existing social protection measures |
Engaging civil society and the private sector

- Reach out and partner with civil society organizations with the human capabilities and knowledge of particular communities, that can help with a coordinated outreach effort.
- Establish partnerships with civil society organizations combating domestic violence
- Engage/incentivize water, gas, electricity, and financial providers to ease the financial burden of essential services and supplies
- Mandate or encourage the elimination of mobile money transfer fees

**2.1 CASH/IN-KIND TRANSFERS**

Unconditional cash transfers (UCTs) have widely been shown to be effective in maintaining food security during humanitarian crises, while also supporting the local economy. As of 10 April 2020, cash transfer programs are the most widely used intervention by governments in response to COVID-19 (143 programs in 81 countries).^{59}

Generally, cash transfers tend to be more cost-effective^{60} than in-kind food distribution and are also less disruptive^{61} to local food prices. However, in this time of reduced market access, it is important to have an additional safety net to ensure those who are vulnerable have access to food and health necessities during quarantine, while reducing the need to travel to and convene in crowded public spaces to do so.

Context matters when deciding whether a transfer program should distribute benefits in food or cash. Food transfers are the most attractive relative to cash transfers in the immediate aftermath of supply shocks that limit local food supply, especially when local food markets are poorly integrated into larger markets. The potential advantages of food distributions also tend to be higher when the foods distributed discourage participation by the non-poor (but not the poor); when prices are unstable and policy institutions are not capable of flexibly adjusting the value of cash transfers; and when financial institutions are poorly developed and security is poor.^{62}

**LESSONS FROM OTHER COUNTRIES**

Multiple governments are using UCTs to insure their populations against the threat of income and consumption shocks from the social distancing measures. For example, the Australian Government of providing financial assistance to around 6.5 million lower-income Australians in response to COVID-19.^{63} Similarly, the US is allocating cash transfers as part of a stimulus package.^{64} Previously, programs have been widely used in other geographies (e.g. Latin America) to cushion against the 2008 Financial Crisis shock.^{65}

Partnering with the private sector to improve supply chains has been proposed for medicine supply chain distribution in low resource settings^{66} and has successfully been carried out in humanitarian crisis-response contexts, including Ebola crisis response. For example, UNICEF worked to develop channel local and international supply chains to provide PPE and other medical materials to families and clinics.^{67}
CONSIDERATIONS FOR CASH/IN-KIND TRANSFERS

1. **When possible, adopt and expand unconditional cash transfers** to support the vulnerable amidst income loss and consumption shocks. **If cash cannot guarantee access to the essential food, supplement/replace unconditional cash transfers with supply and food distribution.**

2. **Ensure safe pay/distribution points and/or use mobile payments.** The implementation of cash transfer programs will be affected by COVID-19, particularly those programs that use in-person delivery of the cash transfers at physical pay points. Mobile payments can provide a safe alternative, but policymakers would need to ensure that digital cash transfers can effectively reach the most vulnerable populations. Other considerations include:
   a. If people will receive transfers at a physical place (post offices, financial institutions, etc.), assign people to days of the month and times of the day to safely queue to receive their payments/distribution of food, minimizing the concentration of recipients waiting at any given time.
   b. Establish hand hygiene stations at every distribution point, and recipients can be directed to wash their hands with soap or disinfect their hands with hand sanitizer before interacting with staff. PPE should be distributed to all staff.

3. **Leverage existing distribution networks** where possible, for example: via NGOs serving these communities or companies with wide-reaching and granular distribution networks.

4. **Where possible, partner with public transportation lines** that access hard-to-reach areas to achieve multiple public health and economic security objectives:
   a. Buy out their time to reduce public health risks of mass public transportation,
   b. Provide a continued source of income for drivers and other transportation workers.
   c. Reach and deliver in-kind transfers to vulnerable areas by leveraging existing transport routes.

2.2 MODIFYING EXISTING SOCIAL PROTECTION INTERVENTIONS

If designing and implementing new programs is not feasible or desirable, modifying pre-existing social protection programs may quickly increase the protection of vulnerable populations. South Africa employed this strategy in its Temporary Employee/Employer Relief Scheme (TERS), which is tied to the existing Unemployment Insurance Fund (UIF) under the Department of Labour.

LESSONS FROM OTHER COUNTRIES

In countries that have not introduced new programs, but instead modified pre-existing interventions, such modifications are pursued via six basic strategies: (i) increased coverage (e.g. Brazil), (ii) higher benefit levels (e.g. China), (iii) advance payments (e.g. Indonesia), (iv) simplifying administrative requirements (e.g. UK, Romania), (v) plugging COVID-response schemes into existing delivery platforms (e.g. Pakistan, Jordan), and (vi) providing innovative design solutions, such as school feeding programs delivering food directly to children’s homes or nearby distribution points (e.g. Jamaica and
India’s Kerala state). Expanding social protection measures should also be done in tandem with a significant communications push (see Section 1.2).70

**CONSIDERATIONS TO MODIFY EXISTING SOCIAL PROGRAMS:**

1. **Increase the number of people covered and providing higher benefit levels by**
   
   a. providing advance payments or lumping payments together.
   
   b. simplifying administrative requirements to make it easy for newly vulnerable people to sign up.
   
   c. plugging into other COVID-response schemes (e.g. supply or food distribution).
   
   d. expanding child support funds because of its reach in poor communities.71

2. **Reach people most affected:** Policymakers should be confident, potentially by using data, that the existing programs can reach those most adversely affected by COVID-19.72

3. **Ensure that the method of disbursing benefits does not result in public health risks** such as crowding or violation of social distancing as discussed above (see Section 1.1).73

**2.3 ADDITIONAL MEASURES TO COMBAT DOMESTIC VIOLENCE**

There is a high risk that the forced confinement and economic stress caused by COVID-19 will exacerbate the problem of domestic violence in the country. South Africa has been facing a domestic violence crisis even before the arrival of COVID-19. Although there are no centralized statistics on incidents and types of violence against women, findings of a 2011 prevalence study in the province of Gauteng conducted by Gender Links and the Medical Research Council found that more than three quarters of men have perpetrated violence against women in their lifetime and more than half of women have experienced gender-based violence.74

**LESSONS FROM OTHER COUNTRIES**

Around the world, evidence is growing that COVID-19 lockdowns are correlated with a steep rise in domestic violence. In France, the police reported a nationwide spike of about 30 percent in domestic violence in the week after their lockdown,75 while India reported double the usual number of gender-based violence cases in their first week after lockdown.76 Similar trends have been reported in China, Argentina, Spain, and Kenya77.

**CONSIDERATIONS FOR COMBATING GENDER-BASED VIOLENCE**

1. **Invest in public awareness campaigns** to highlight this risk and give detailed information on how survivors, including those infected with COVID-19, can access services.

2. **Services for survivors should be treated as essential**, and adequate PPE should be provided to those responding to distress calls.

3. **Establish referral linkages between health facilities and services available locally** (e.g. hotlines, shelters, rape crisis centers, counselling) for survivors78.
2.4 PROVIDING ADDITIONAL SUPPORT TO INFORMAL WORKERS

South Africa’s unemployment rate stood at 29.1% (over 50% for youth) in late 2019, and has likely increased as a result of the pandemic. Informal workers dominate the everyday economy in the country’s townships, villages and inner-city areas. They number at least 3 million (an estimated 18% of the total workforce), with many more dependents. Informal workers are particularly vulnerable to COVID-19, as many are based in crowded townships or inner-city slums, where options for social distancing are constrained.

Informal workers also play a vital role in the provision of food to local communities and in addressing their basic needs, particularly in townships. Several associations of informal workers are organizing and lobbying the government for support, including the Informal Traders Alliance and the South African Waste Pickers Association.

LESSONS FROM OTHER COUNTRIES

Unconditional cash transfer programs, described in Section 2.1, provide a direct channel for providing financial relief in the hands of informal workers. Cash transfer programs in Zambia and Malawi targeted “ultra-poor, labor-constrained households” by using demographic data. Similar methods can be used in South Africa to target time-bound COVID-19 cash transfer programs to informal workers.

Some countries have adopted mechanisms to benefit informal workers. For example, El Salvador has granted a waiver for business loan repayments, as well as utility bill repayments and credit card debt in an attempt to give emergency credit to workers in the informal sector.

CONSIDERATIONS FOR SUPPORTING INFORMAL WORKERS:

1. Administrative and big data can be used to identify areas that have concentrations of informal workers or other vulnerable populations. Beneficiary registries, program management information systems, and other public datasets can be used to build risk profiles for different categories of beneficiaries and regions. This information can inform the targeting of COVID-19 economic responses to ensure resources are allocated to populations most in-need.

2. Leverage existing social protection measures such as the Child Support Grant, Care Dependency Grant, and Older Person’s Grant can also be used to target informal workers and provide them with resources.
BOX 3. ENGAGING CIVIL SOCIETY AND THE PRIVATE SECTOR TO FACILITATE SOCIAL PROTECTION RESPONSE

Even in ordinary times, civil society organizations play an essential role in shaping and supplementing social protection policies\(^87\). In the context of COVID-19, where emergency social protection measures are rolled out by governments on a weekly basis to cushion economic shocks, their participation in the policy design and implementation process is even more critical.

Responses from the private sector can also reduce the economic burden for those affected, freeing up public resources for activities that are firmly within the state’s purview, such as ensuring the continued provision of education, health care, infrastructure, and other basic public goods.

LESSONS FROM OTHER COUNTRIES

In West Africa, youth mobilization was key to community responses to Ebola.\(^88\) In the case of COVID-19, NGOs could also deliver essential services like shelf-stable food and hygiene products to more vulnerable neighbors, making social distancing possible. Out-of-school or unemployed youth may be interested in supporting their communities during COVID-19.\(^89\)

In Kenya, where adoption of mobile money is widespread, all major telecom networks eliminated mobile money transfer fees after a public appeal by the national government\(^90\). Argentina, Belgium, Colombia, El Salvador, and Spain have measures in place to prevent the disconnection of key utilities/services during the COVID-19 crisis\(^91\).

ENGAGING CIVIL SOCIETY: MESURES TO CONSIDER

1. Reach out and partner with civil society organizations with the right capabilities and knowledge of particular communities that can supplement Government’s protection of the vulnerable. Potential partners may include those with broad distribution networks or close community ties, such as international and local NGOs, religious groups and institutions, youth groups, women’s groups, or microfinance groups that may have access to hard-to-reach areas. The government can also set-up coordination structures to ensure entire territories are covered adequately.

2. Establish partnerships with civil society organizations combating domestic violence to amplify public communications and reinforce service capacity.

ENGAGING THE PRIVATE SECTOR: MESURES TO CONSIDER

3. Engage/incentivize water, gas, electricity, and financial providers to explore opportunities to ease the financial burden of essential services and supplies.

4. Mandate/incentivize the elimination of mobile money transfer fees to reduce the risks associated with exchanging cash and facilitate access to savings and loans for those excluded from the formal banking system.
C. DECISION MAKING TEMPLATE

IDinsight has developed the following decision-making framework to help our partners at the National Development Agency and the Department of Social Development think through COVID-19 response policy options, paying particular attention to any unintended consequences of potential policies. A broader policy-making checklist is included in the appendix. These frameworks should not be considered an exhaustive list but a complementary tool to facilitate decision-making.

The framework is structured in three parts. **Part A** features key questions that should be considered when exploring policy options to address a given problem. **Part B** uses the information gathered in Part A to identify the best policy option by carefully assessing and weighting costs and benefits. Finally, **Part C** describes areas where civil society partnerships and data may facilitate program design, implementation, and learning.

<table>
<thead>
<tr>
<th>Key steps</th>
<th>Promote healthy community behavior</th>
<th>Bolster social protection measures for the vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Explore policy options and consider implications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Problem, Objectives, Evidence</td>
<td>• What barriers (i.e. knowledge, attitude, and behavior) exist for adopting healthy actions?</td>
<td>• What short/long-term damage would occur if no protection is provided?</td>
</tr>
<tr>
<td></td>
<td>• What community actions are favoring the spread of the virus?</td>
<td>• Is the program intended primarily to reduce vulnerability or encourage targeted behaviors?</td>
</tr>
<tr>
<td>2. Potential Courses of Action and Direct Effects</td>
<td>• What options could relax the binding constraints/reduce key barriers?</td>
<td>• What are the implications of modifying existing policies/programs vs creating new ones?</td>
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<tr>
<td></td>
<td>• What population(s) will benefit (i.e. health outcomes/behavior)/be adversely impacted? How much? When?</td>
<td>• What population(s) will benefit (i.e. essential consumption, intra-household distribution)? How much? When?</td>
</tr>
<tr>
<td></td>
<td>• If the policy involves social distancing, what kind/unit of social distancing is politically and operationally feasible?</td>
<td>• Could vulnerable populations not benefit in practice? What are the barriers?</td>
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<tr>
<td></td>
<td></td>
<td>• Cash vs in-kind transfers? Conditionality?</td>
</tr>
<tr>
<td>3. Spillovers</td>
<td>• Will the policy create any disruptions in critical services/economy/liberties?</td>
<td>• Does the channel of delivery favor the spread of the virus?</td>
</tr>
<tr>
<td></td>
<td>• Could the policy endanger the vulnerable (e.g. HIV ARV drug supply issues, domestic violence)?</td>
<td>• Do beneficiaries change their behavior?</td>
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<tr>
<td></td>
<td>• Can we mitigate any negative effects? How? At what cost?</td>
<td>• How well does the program limit leakage to the non-vulnerable?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will any populations be adversely impacted? How much? When?</td>
</tr>
<tr>
<td><strong>B. Evaluate policies and choose the most appropriate option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Decision-making criteria</td>
<td>• Explicitly define/quantify weights for anticipated benefits, costs, and trade-offs for each population</td>
<td></td>
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<tr>
<td></td>
<td>• Identify data/evidence gaps</td>
<td></td>
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<tr>
<td></td>
<td>• Evaluate feasibility of the policy by considering required inputs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Choose optimal policy option</td>
<td></td>
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</tbody>
</table>

**C. Leverage civil society and data for implementation and learning**
5. Civil Society Support

- Partner with civil society organizations, trusted traditional leaders, and respected figures to design and advocate for behavior change policies
- Consider civil society organizations to help improve targeting/ design of the program
- Engage/incentivize private sector to protect vulnerable populations

6. How can data help?

- Identifying health, socioeconomic, knowledge, attitude, practice, and geospatial characteristics to inform communication/social distancing design
- Assessing progress of implementation
- Providing accurate real-time picture of the trajectory of the outbreak
- Identifying patterns of agglomeration
- Finding most cost-effective way to favor healthy behaviors
- Identifying health, socioeconomic, and geospatial characteristics to inform design
- Informing and assessing effectiveness of targeting and program implementation
- Estimating impact on consumption expenditure, nutrition, household labor supply, intra-household distribution and any behaviors rewarded or penalized by behavioral conditions

ABOUT THE NATIONAL DEVELOPMENT AGENCY

The National Development Agency (NDA) is a Schedule 3A public entity, established by the Act of Parliament known as NDA ACT of 2008, to strengthen the capacities of civil society organizations in South Africa and to create platforms for debates and dialogues between the state organs and civil society on development policy in South Africa. It reports to Parliament through the Minister of Social Development. Its role is to empower and enhance the capacity of the civil society sector to tackle the triple threat of poverty, unemployment and inequality. In light of the COVID-19 crisis, the NDA is partnering with IDinsight to develop and disseminate policy insights within the South African government, with the goal of informing the national response to the pandemic.

ABOUT IDINSIGHT

IDinsight is a global advisory, data analytics, and research organization that designs, deploys, and promotes evidence-generating tools to help leaders improve lives. We tailor gold-standard methodologies to practitioner needs and enable continuous improvement by using the right tool at the right time. We define success by the decisions and actions that our work informs. Our team is helping governments navigate the COVID-19 crisis by tailoring public policy recommendations to their contextual needs and circumstances. We currently support public policy efforts with governments and international partners across Africa, India, and South-East Asia.

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## APPENDIX 1: POSSIBLE MEASUREMENT TOOLS

<table>
<thead>
<tr>
<th>Tool</th>
<th>Function</th>
<th>Description</th>
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</table>
| **Theory of Change**             | • It maps how program inputs are expected to lead to activities and outputs that will achieve impact.   | • A theory of change is a narrative about how and why the program will work.  
• It also documents assumptions to get from one step to another and any possible risks along the way.  |
| **Needs Assessment**             | • They can tell you characteristics and problems facing your target population as well as their prevalence to help target the program. | • Needs assessments describe the context in which your program operates (or will operate).  
• They rely on surveys, interviews, and observations that many organizations have the capacity to conduct on their own. |
| **Landscape and Evidence Review**| • Can tell you more about the nature of the problems you’re trying to solve, whether there is existing support for your program design, what interventions have or have not worked in the past. | • Landscape and evidence reviews summarize findings from previous research related to your program.  
• Landscape and evidence reviews can be done internally by someone with experience interpreting research findings. |
| **Preference Elicitation**       | • They can inform specific elements of your program design such as how much to charge for your product or services. | • Preference elicitation studies measure the beliefs and preferences of potential program beneficiaries. |
| **Process Evaluation**           | • Can identify implementation gaps, areas where additional oversight is needed, and assumptions about the ways your program achieves success that do not hold. | • Process evaluations assess whether your program implementation is running as expected. |
| **Impact Evaluation**            | • Can tell you whether your program is working and how big of an effect it is having.  
• Impact evaluations of different program designs (often called A/B tests) can tell you which implementation model is most effective. | • Impact evaluations measure the effect of your program on the outcomes it is trying to change.  
• Impact evaluations require expertise on statistics and research methods and the ability to collect and analyze data. |
| **Monitoring**                   | • It can tell you where your program implementation is doing well and where it’s falling short. | • Monitoring systems collect data about your program performance and provide real-time updates on implementation.  
• Monitoring requires collecting, storing, analyzing, and visualizing data. The ability to do this efficiently can help improve usability of the system. |
| **Data analytics**               | • **Modeling:** You can build models to compare different scenarios; for example, to explore the relationship between key assumptions, inputs and programmatic costs, and/or outcomes. | • Data analytics encompasses a broad range of activities that go beyond the data analysis typically conducted as part of an evaluation. These include, but are... |
| **Analysis**: You can use existing data to explore operational and contextual questions about a program and/or quickly test initial hypotheses about a program’s impact. | not limited to: modelling, analysis, and visualization. |
| **Visualization**: You can use visual techniques to represent, analyze, and interact with data, with the ultimate goal of informing decisions. | |

| **Machine Learning** | **Machine learning involves creating algorithms that are trained using existing data to make out-of-sample predictions.** |
| **You can use data (usually a lot) and statistical algorithms to predict something unknown** | **Algorithms refer to a variety of predictive functions, including regression (including regularized regression), decision tree models, clustering techniques, and neural networks.** |
| **Useful for addressing prevention problems (e.g. predicting where is disease is likely to spread to inform the distribution of public health aid) and data-void problems (e.g. trying to determine which villages have the highest malnutrition rates when the available data is not granular, recent, or accurate enough to answer the question)** | |
APPENDIX 2: GENERAL DECISION-MAKING CONSIDERATIONS

DEFINE THE PROBLEM AND ASSEMBLE THE EVIDENCE

- What is the issue or problem? What are the binding constraints/barriers keeping us from overcoming it?
- What do we not know? What are the established facts of the issue or problem? What complementary evidence is available?
- Who is affected by this decision? How does each stakeholder see this issue and what is motivating or informing their perspective?

IDENTIFY POTENTIAL COURSES OF ACTION AND DIRECT EFFECTS

- What are all of the options or actions (including doing nothing) we could take to solve the problem? Are they operationally and politically feasible?
- How would each option achieve the desired objectives? What are the anticipated barriers to implementation and risks? What are the assumptions for success?
- What resources/inputs/skills will be needed? Will partnerships be needed? What are the budgetary costs of the policy, and how do they vary over time?
- What sorts of individuals, households or firms are directly affected by the policy, how large are these groups?
- What effect do we expect the policy to have on the well-being and behavior of those directly affected in the short, medium and long run?
- If there are inadequate resources to adequately respond to each eligible individual, how would resources be allocated?

ASSESS EXTERNALITIES AND/OR IMPACT ON THE VULNERABLE

- Does the policy maximize net benefit to the public? What are the trade-offs? (including the spread of disease, disruption to essential activities and services, limiting privacy and personal liberties of individuals, etc.)
- Are there contingency plans in case the decision does not have the intended outcomes, or creates possible conflicts?
- How does this measure affect these vulnerable groups? How much? When?
  - Informal workers
  - Homeless populations
  - People 65 years or older
  - People who live in a nursing home or long-term care facility
  - People living with HIV/AIDS (PLWHA), TB, and other underlying medical conditions
  - Others?

SELECT THE POLICY, IMPLEMENT, AND LEARN

- What are the criteria to include to rank policy options? How do we weigh the critical factors?
- What are the advantages and disadvantages of each option? What are the trade-offs?
- Are there opportunities to work with partners to fill in any gaps/improve the solution?
- What option is superior according to the established criteria?
The state of basic service delivery in South Africa: Inequality, poverty, and the right to health

Key pandemic spread indicators include: 1) the number of individuals who have tested positive for COVID-19, 2) the corresponding number of tests performed (for correct interpretation of the progression of the pandemic), 3) the number of persons under investigation (PUIs) at health facilities, 4) the numbers of confirmed positive cases per confirmed cases as a result of the contact tracing process, 5) the outcomes of mass and randomly sampled screening and testing drives. Key health system capacity metrics include: 1) hospital bed capacity at various levels of care (general, high-care, critical), 2) real-time hospital bed occupation levels, 3) stock levels of personal protective equipment (PPE), 4) the number of registered healthcare practitioners, both in-service and retired. Source: https://www.medrxiv.org/content/10.1101/2020.04.07.20057133v1.pdf


People over age 60, people who are immunocompromised including HIV patients, people with chronic lung disease or asthma, severely heart conditions, diabetes, kidney or liver disease, and other chronic conditions, from the CDC.

https://www.theic.org/project/the-economic-implications-of-ebola/


Section A

How and when will we communicate with the stakeholders?

What data will we need to make sure implementation is on track, adjust the policy, and learn from the program? How often do we need to make decisions based on these data?

When and how will we learn from the policy implementation?

How will that data be collected and analyzed?

How will data be translated into insights and actions?

Who will be responsible for each step of the data demand and supply cycle (see Figure 1, Section A)? What resources and capabilities will they need?


3 According to the Oxford COVID-19 government response tracker, the South African lockdown is among the most stringent in the world, scoring the maximum possible score of 100 on their Stringency Index.


Ministry of Community and Social Services (MCSS), & German Technology Cooperation (GTZ). (2007). Final evaluation report: Kalomo social cash transfer scheme.


People with chronic lung disease or moderate to severe asthma, serious heart conditions, severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease, liver disease, or people who are immunocompromised.