Development of a Country report on the measures implemented to combat the impact of COVID-19 in South Africa

Interview Dr Andreas Jansen, Head of the Federal Information Centre for International Health Protection, Robert-Koch-Institute Berlin (JansenA@rki.de)
Friday 22 January 2021 (9:00-10:15 Germany, 10:00-11:15 South Africa)

Questions sent to Dr A Jansen:

- How do you view the medicine and health-related measures which were planned and initiated by the government of Germany to slow down and reduce infections, including planning and coordination of lab testing strategies?
- How do the new coronavirus variants affect the mitigation strategies?
- Can you comment on the vaccine roll-out in Germany?
- How do the measures taken in Germany compare with the South African response?
- How do you view the process from a social development, social protection, community and human development perspective, including protection of vulnerable populations?
- How do you view the process from a basic and higher education perspective?
- How do you view the process from a food supply chain perspective?
- How do you view the process from an economic perspective and related to saving livelihoods in the different sectors?
- What were your experiences during conceptualisation, design and implementation of the interventions on COVID-19?
- Which was the role played by stakeholders outside of government including various industries, other economic partners and the general public?
- How successful was government in establishing social trust and buy-in at all stages of lockdown and in the rollout of the vaccine, given the anti-vaccination lobby and uncertainty on the effectiveness of the vaccines against some new variants?
- Did government have to pay a non-refundable deposit to secure advanced market commitments?
- What were the terms negotiated with the manufacturers to get such big volumes of vaccines?
- Has there been an appropriate communication strategy and adequate sharing of resources within government of Germany at national, provincial and local levels?

- What were the weaknesses in the whole process, and what could have been done better?
- Do you know similar reports being prepared by other countries or regions? In this case, can you recommend contact partners?
- Do you have any further comments or suggestions for this project?

The objectives of the interview were explained to A Jansen via email, and the information sheet was sent on 19 January. A Jansen signed the informed consent form.

A Jansen introduced himself and his Department. This was established based on a decision of the German government in the aftermath of the Ebola outbreak in West Africa, with the aim to strengthen international cooperation at the Robert-Koch-Institute. In 2020, approx. ten international missions were accomplished, including Namibia and other African countries. A Jansen has good insight in the Covid-19 situation in South Africa due to personal contacts.

Currently, the incidence figures are quite similar in SA and Germany (WHO, cases/7 days/100,000: SA – 188 vs Germany – 149 new cases; SA – 6.8 vs Germany – 7.3 deaths). The strict measures implemented in SA during the first wave were very effective, although some enforcements of the severe restrictions were considered beyond the law (e.g., police violence). The scientific basis for some of the restrictions (tobacco ban and strict alcohol prohibition) was unclear.

The adjustment/increase of testing capabilities in SA is considered adequate, with some gaps in certain areas.

The new variants are of major concern in Germany and elsewhere in Europe, primarily because of the higher rate of transmissions. In Germany, the "UK variant" is most relevant at this time. It is expected that the more contagious variants could result in more travel restrictions and in reduced vaccination success.

In Germany, there is adequate ICU bed capacity, despite the recent high incidence numbers. This is different in some other European countries which struggle with ICU bed availability, especially considering the recent increased incidence numbers.

E du Plessis commented that in SA the science behind some of the decisions was unclear, such as school closure. G Gray reported that the Ministerial Advisory Committee (MAC) recommended immediate opening of the schools with a differential approach for certain classes. This advice was not followed. Another example is the previous recommendation not to allow taxis to operate at full capacity which was not followed, due to powerful lobbying of the taxi organisations.

A Jansen referred to Max Weber's ethic of responsibility (*Task of scientists is to report the facts impartially to politicians when they are instructed to do so, allowing the political leaders to then decide how these facts fit their values and their vision for society and to answer for the consequences of their actions.* – see: https://theconversation.com/coronavirus-has-put-scientists-in-the-frame-alongside-politicians-and-poses-questions-about-leadership-148498).

Evidence-based advice for specific measures is available, e.g. in the UK, Norway and Canada. A Jansen recommended to review these and provided contact details for the expert in

Norway, Frode Forland. In general, there are no good nationwide studies, since countries were not well prepared and scientists did not understand their role in this respect.

In Germany, evidence-based decision taking is often blurred. Scientists cross the borders of their fields ("Virologists become epidemiologists"), and their role in decision making is determined by number of their TV appearances. The federal system with 16 Ministries of Health causes confusion resulting in a "complete mess" for the schools. In a crisis, A Jansen recommends political leaders should work as one and avoid politically motivated discussions (government vs opposition).

Vaccines:

In Germany, politicians and administrators responsible for the vaccine roll-out are accused of failure to supply adequate amounts of vaccines. Given the huge task of organising an adequate logistics on a world-wide basis, this is unjustified. The use of the terms such as "vaccine apartheid" by WHO experts (https://www.euronews.com/2021/01/19/vaccine-apartheid-palestinians-left-behind-as-israel-sprints-ahead-with-covid-vaccinations) or "German vaccine" is counterproductive.

G Gray mentioned the slow procurement of vaccine in SA. In contrast, Kenya, Mexico, Argentina and Algeria already have received vaccine doses. A Jansen commented that there are not enough supplies and the total number of doses distributed to these countries is rather low. For access by poor countries, it is important to know the right people and to have pre-existing relationships. This is the case for the vaccines from China and Russia.

The example of Usbekistan which only recently opened up shows that a country with a lack of international relationships is not considered as customer. They had offers from China and Russia, and also approached companies such as Pfizer and Moderna, but only received 100,000 doses from BioNTech so far.

Italy obtained some of its supplies from China and Russia. Namibia is supported by Germany in form of a "Twinning Project". Ideally, 200,000 doses should be sent at an early stage for healthcare workers, but it is unclear if this will remain possible, given the current discussion about under-supplies in Germany.

The Covax initiative is expected to deliver vaccine supplies to target countries in April/May, but may not work at all. This separation into first- and second-class world reflects a failure of global solidarity. A recent publication in the Foreign Affairs Magazine alerted to the fact that adequate vaccine supply to LMICs will be required to avoid losing credibility (see also: Global Preparedness Monitoring Board (GPMB) publication "A World in Disorder", Sept. 2020).

Vaccine procurement plans should take into account that annual vaccinations most likely will be necessary.

Other:

There are no supply shortages in Germany (except the perceived "toilet paper crisis"). This includes food supplies. Country borders were never closed for trade. The social system is working, and the degree of poverty is much less than in SA.

Severe long-term effects on the economy are to be expected. In Germany, the huge fiscal debt will affect future generations.

In general, there has been good communication with industry in Germany. In SA, the restaurant industry was never consulted. The situation is similar in Germany. There is no good scientific basis for closure of restaurants many of which have been able to implement appropriate measures against virus spread.

Differences between public vs private schools regarding school openings and available infrastructure result in injustices which will enforce previously existing discrepancies. Missing education and lower quality exams may lead to a generation of “Covid graduates” with perceived lower quality degrees.

China has been able to stop the virus by sending 15-20 million people in full lockdown when only few infections were detected and organising a comprehensive support system for them at their homes. This approach would hardly be feasible elsewhere due to capacity constraints.

These notes of the discussion were approved by A Jansen on 25 January 2021. He agrees to the use of these approved minutes in the context of the Covid-19 Country Report.

Prof. Bernd Rosenkranz