IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NUMBER: 2023-132918

In the matter between

SAKELIGA NPC	Applicant
And	
THE MINISTER OF COOPERATIVE GOVERNACE AND TRADITIONAL AFFAIRS	First Respondent
THE NATIONAL DEPARTMENT: COOPERATIVE GOVERNANCE	Second Respondent
THE DIRECTOR-GENERAL IN THE DEPARTMENT OF COOPERATIVE GOVERNANCE	Third Respondent
THE INFORMATION OFFICER: THE NATIONAL DEPARTMENT OF COOPERATIVE GOVERNANCE	Fourth Respondent
THEMBI NKADIMENG	Fifth Respondent
MBULELO TSHANGANA	Sixth Respondent
THINAYHYO SKOSANA	Seventh Respondent
NKOSAZANA CLARICE DLAMINI ZUMA	Eighth Respondent
THE PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Ninth Respondent

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REPLY TO APPLICANT'S NOTICE IN TERMS OF RULE 35 (12)

SIGNED at **PRETORIA** on **13 NOVEMBER 2024.**



DEFENDANT'S ATTORNEYS

STATE ATTORNEY PRETORIA

SALU BUILDING

CNR THABO SEHUME STREET &

FRANCIS BAARD STREET

PRETORIA

TEL: 012 309 1507

EMAIL: OSebitso@justice.gov.za

REF: 0061/24/Z71

ENQ: Ms O Sebitso

TO: REGISTRAR OF THE ABOVE HONOURABLE COURT

PRETORIA

AND

TO: KRIEK WASSENAAR & VENTER INCORPORATED

Third Floor HB Forum Building

13 Stamvrug Road

Val De Grace

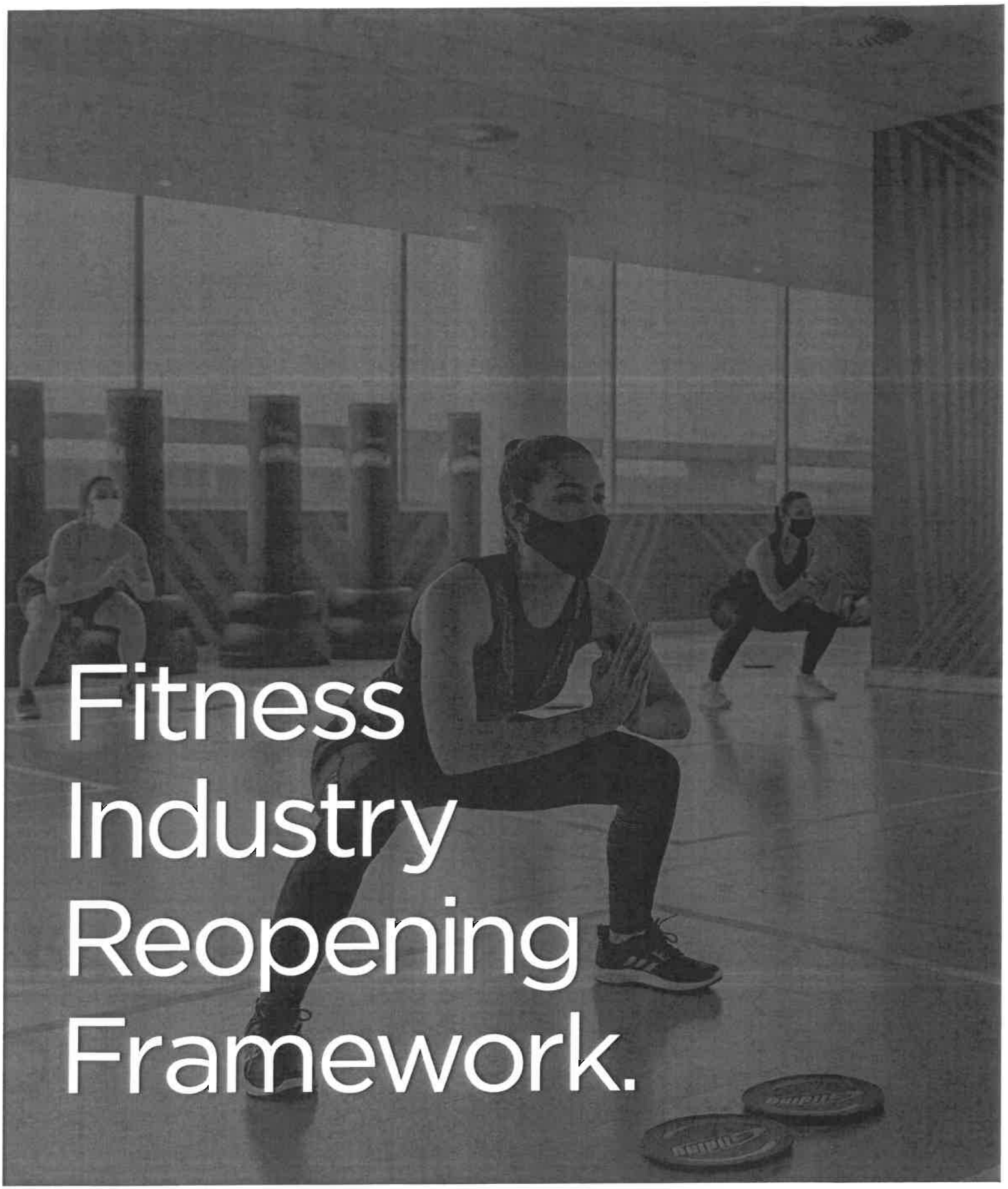
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Ref: Y Mouton/QB0792



Fitness Industry Reopening Framework.

A framework for the re-opening of gyms, fitness centres and the wider fitness industry during social distancing restrictions.

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Definitions

"Any person" – means users, members, customers, tenant, visitors, staff, suppliers, service providers vendors and contractors.

"Comorbidities" – means underlying health conditions that would make a person more susceptible to severe or acute health problems as a result of COVID-19. These comorbidities could be in people who:

- have had an organ transplant.
- are having chemotherapy or antibody treatment for cancer, including immunotherapy.
- are having an intense course of radiotherapy (radical radiotherapy) for lung cancer.
- are having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors).
- have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma).
- have had a bone marrow or stem cell transplant in the past 6 months, or are still taking immunosuppressant medicine.
- have been told by a doctor they you have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD).
- have a condition that means they have a very high risk of getting infections (such as SCID or sickle cell).
- are taking medicine that makes them much more likely to get infections (such as high doses of steroids or immunosuppressant medicine).
- have a serious heart condition and are pregnant.
- are 60 or older.
- are pregnant.
- have a lung condition that's not severe (such as asthma, COPD, emphysema or bronchitis).
- have heart disease (such as heart failure).
- have diabetes.
- have chronic kidney disease.
- have liver disease (such as hepatitis).
- have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy).
- have a condition that means they have a high risk of getting infections.
- are taking medicine that can affect the immune system (such as low doses of steroids).
- are very obese (a BMI of 40 or above).

"Contact tracing" – means the process of identifying persons who may have come into contact with a COVID-19 infected person and subsequent collection of further information about these contacts.

"Control Measures" – means actions and/or activities that are taken to prevent, eliminate or reduce the occurrence of a hazard that has been identified. In this case the hazard is COVID-19.

"COVID-19" – means Coronavirus Disease 2019.

"Fitness Facility" – means a health, recreational, and social facility geared towards exercise, sports, and other physical activities.

"Operator" – means a person or company that runs a fitness facility.

"Safe Work Practices" – means written methods detailing how to perform a task with minimum risk to people, equipment, materials, environment, and processes.

Overview

This document sets out the framework for opening fitness facilities during an anticipated period of "social distancing, increased focus on cleaning and extra hygiene protocols" following the full closure of the sector due to COVID-19. It also provides the basis for individual operators to develop their own COVID-19 opening plan for the safety and wellbeing of customers, staff and supply chains once the Government has said fitness facilities, or parts of fitness facilities, can open.

The framework has been developed based on global best practice and has been reviewed by leading medical experts.

The Fitness Industry will have a vital role in ensuring the ongoing health and wellbeing of the nation following the lifting of COVID-19 restrictions. We believe this role has never been more important than at the current time in helping the country regain its health. The industry must however open with the appropriate screening, social distancing and hygiene controls which prevent or limit transmission risk.

This framework is not intended to be exhaustive in covering every possible scenario but aims to provide a clear direction for the industry to follow. Nor is it intended to cover all aspects of every operator: there may be special undertakings for those with specific offerings. Operators can make their own decisions and can go above the standards within this document, but not lower.

The guidance provided in this document is to be used during COVID-19 Alert Levels 3 and 2. Additional guidance will be provided when the country moves to COVID-19 Alert Level 1.

General Guidance

This section details minimum general guidance that all operators within the Fitness Industry are required to adhere to.

1. Operators must comply with all Government guidance and regulations.

2. All fitness facilities must have a COVID-19 opening plan. The plan must provide detail on the control measures that will be implemented to prevent the spread of COVID-19 within the facility / facilities. The opening plan must cover at least the following control measure categories:
   - Wellbeing of staff and users / visitors.
   - Social Distancing.
   - Cleaning and Hygiene.
   - Contact Tracing.

Refer to the section Develop a COVID-19 opening plan on page 13 of this framework document.

3. Every operator must appoint a COVID-19 compliance manager in all facilities. This role is to ensure all the control measures are adhered to everyday.

4. All staff members / employees must be trained in the COVID-19 opening plan.

5. A poster or display screen must be positioned at the entrance to the facility, detailing all of the COVID-19 control measures that users need to follow whilst in the facility.

6. Every operator must have a health screening process in place to prevent any person who has COVID-19 symptoms from entering into the facility.

7. Any person entering and using the facility must wear a cloth mask at all times.

8. Any person entering and using the facility must adhere to Government specified social distancing requirements at all times. It is the facilities operators' responsibility to have a COVID-19 opening plan in place to manage these requirements.

9. Operators must have a daily cleaning and disinfection plan in place, using antiviral disinfectant.

10. Hand Sanitiser must be available for use at the entrance to the facility and at various locations inside the facility.

11. Posters or display screens must be positioned at various locations throughout the facility informing any person of the COVID-19 control measures that they must follow whilst in the facility.

12. For contact tracing purposes, operators must record the time, date, full names and contact details of any person entering the facility and this information must be stored in a safe place for 28 days.

Specific Guidance

This section details specific guidance that all operators within the Fitness Industry are required to adhere to, relevant to the following categories:

- Wellbeing of Staff and Users / Visitors.
- Social Distancing.
- Cleaning and Hygiene.
- Contact Tracing.
- Safe Work Practices.

Wellbeing of Staff and Users / Visitors

This section detail specific guidance that all operators within the Fitness Industry are required to adhere to for the wellbeing of any person entering or using their facilities.

This section covers:

- The Screen/reporting of symptoms
- Age Restrictions and Comorbidities
- Personal Hygiene
- Face Masks
- Face Shields or Protective Screens
- First Aid
- Staff Members: Rotation, shift work and working at home
- Travelling to and from work
- Suppliers and Contractors
- Returning to training after lockdown



Screening/reporting of symptoms

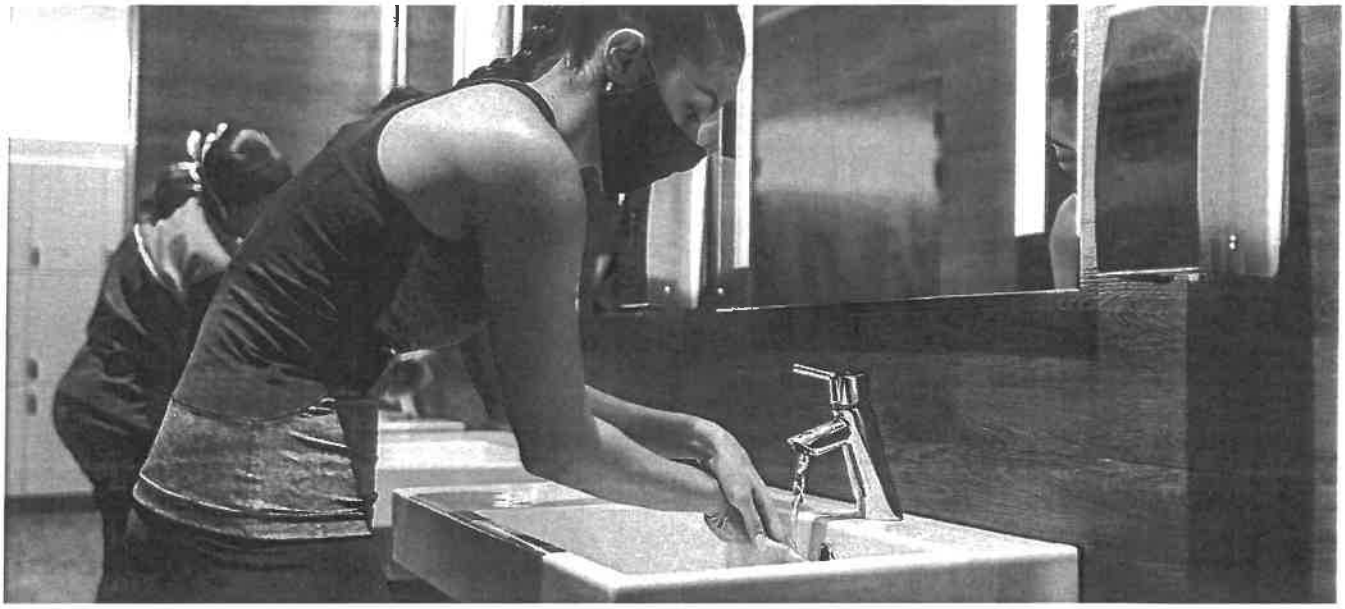
1. Before any person enters a fitness facility, they must undergo a screening and symptom check to identify the following:
   - Temperature (fever) - normal temperature range is between 36.5 and 37.5 degrees Celsius – Anyone with the temperature of > 38 °C must be denied access into the facility.
   - Cough
   - Sore throat
   - Redness of eyes
   - Shortness of breath (or difficulty in breathing)
   - Body aches
   - Loss of smell or loss of taste
   - Fatigue
   - Weakness
   - Tiredness

Screening/reporting of symptoms

2. If any person is suffering from any of the above symptoms, they must not be allowed into the facility and they must be advised to get tested for COVID-19 or referred for medical surveillance and testing.
3. If any person does not have any of the above symptoms, they can be allowed to enter the facility.
4. Operators must record the time, date, full names and contact details of any person entering the facility and this information must be stored in a safe place for 28 days. This will assist the Department of Health with any contact tracing information if required.
5. Any person who is displaying symptoms of COVID-19, detailed above, while in the facility must be isolated and the facility operator must call the National Institute of Communicable Diseases (NICD) hotline - 0800 029 999, for advice.
6. If an employee, tenant or contractor is already at the workplace and displays COVID-19 symptoms, or informs their Manager of these symptoms, the Manager must:
   - Isolate the worker and provide them with a surgical mask and call for an ambulance.
   - Assess the risk of transmission, disinfect the area where the employee had been working.
   - Undertake contact tracing and refer those workers who may be at risk for screening.
   - Take any other appropriate measures to prevent possible transmission.
   - Place employees on paid sick leave.
   - If the employee's sick leave is exhausted, make application for an illness benefit in terms of the COVID-19 Temporary Employer Relief Scheme (TERS).
   - Ensure that the employee is not discriminated against on grounds of having tested positive for COVID-19.
   - If there is evidence that the worker contracted COVID-19 arising out of the course of employment, lodge a claim for compensation in terms of the Compensation for Occupational Injuries and Diseases Act (COID).
7. If any person informs the facility operator that they have been diagnosed with COVID-19, the operator must identify when the person was in the facility and which areas of the facility the person had used. This area must be cleaned and disinfected.
8. If by not allowing an employee into the facility or isolating a worker whilst at work reduces the staffing levels below to what is required to respond to a medical emergency, or the cleaning and sanitisation protocols can no longer be completed, the facility must be closed.

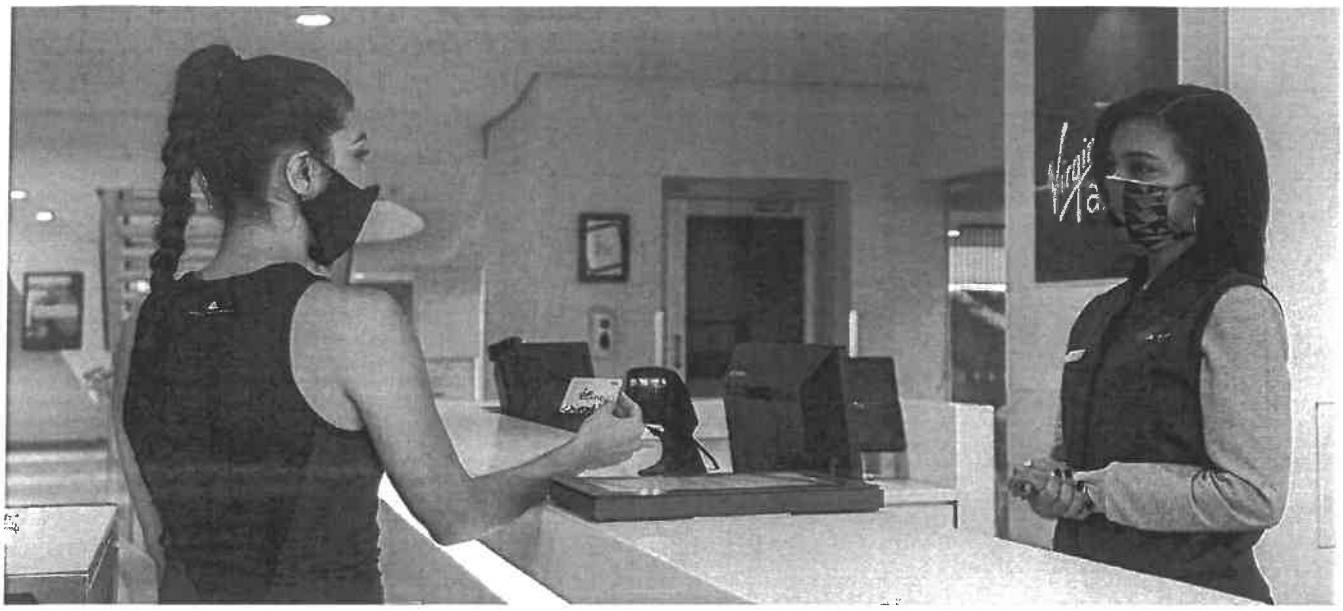
Age Restrictions and Comorbidities

1. Employees and service providers (for example Group Training Instructors) over the age of 60 must be screened for Comorbidities. Those who screen positive for Comorbidities must be encouraged to seek medical clearance before returning to work.
2. Where possible, staff and service providers older than 60 or who have Comorbidities must be allowed to work remotely or be accommodated in low risk roles.
3. All members or users must be informed of the risk of using a club if they are over 60 or have existing Comorbidities and be strongly encouraged to seek clearance from their doctor before using the Club.
4. An employee should consult a medical practitioner if they do not feel safe to work.



Personal Hygiene

1. Operators must provide training to employees about the benefits of washing and sanitising their hands before the start of their shift and regularly throughout the day.
2. Water and hand soap must be available in the changing rooms.
3. Posters must be placed around the facility encouraging any person to:
   - Regularly wash their hands with soap and water for 20 seconds.
   - Cough or sneeze into their flexed elbow or into a disposable tissue and dispose of the tissue into a bin.
   - Avoid touching your eyes, nose and mouth.
   - Avoid contact with infected people.
   - Stay at home if you feel ill.
   - Wear a cloth face mask.
   - Disinfect fitness equipment before and after use.
4. Operators must provide employees with information that raises awareness of the dangers of COVID-19, the manner of its transmission, the measures to prevent transmission such as personal hygiene, social distancing, use of masks, cough etiquette and where to go for screening or testing if an employee has COVID-19 symptoms.



Face Masks

1. The operator must, for every employee, contractor, tenant, instructor:
   - Provide, free of charge, a minimum of two cloth masks, which comply with the requirement set out in the guidelines issued by the Department of Trade, Industry and Competition.
   - As cleaners are at a high risk of COVID-19 infection they must wear an FFP2 mask while carrying out cleaning tasks. The FFP2 mask must be provided by the facility operator.
   - Train the employee in the correct use of the face mask.
2. It is the responsibility of the employee, contractor, tenant, instructor to:
   - Wear this mask at work and whilst commuting to and from work.
   - Wash, dry and iron their mask daily in accordance with the manufacture's guidelines.
3. Any person entering the facility must wear a mask, even when training.
4. If any person chooses to wear a face shield, this must not replace the face mask. They must wear the face shield and the face mask.

Face Shields or Protective Screens

1. If the operator determines that additional protection from COVID-19 infection is required for certain employees, contractors, tenants, instructors as a result of their work requirements, the operator must provide face shields for these persons. An example of this would be employees working at the entrance of the facility and coming into contact with high numbers of persons entering the facility.
2. Protective screens can also be used as an alternative to face shields to segregate employees, contractors, tenants, instructors from users. An example would be a protective screen on a desk at the entrance to the facility to allow an employee to conduct symptom screening for any persons wanting to access.

First Aid

Bacteria and viruses can be present in blood, vomit, faeces and other bodily fluids. Employees and users can be exposed to such fluids/solids during first aid incidents and when a person is unwell.

1. Disposable gloves must be worn when handling body fluids or materials which may have been contaminated with body fluids.
2. Glove wearing does not replace the need for hand washing – hands must be washed after wearing gloves.
3. Resuscitation Ventilation Aids must be worn when administering breaths during a First Aid Incident and disposed of after use. The standard training given to first aiders and the usual precautions taken to reduce the risk of transmitting infections will be effective against infectious diseases (i.e. Hepatitis, HIV/AIDS, COVID-19).
4. The following precautions must be taken to reduce the risk of transmitting the COVID-19 virus whilst administering first aid:
   - Treat every patient as a potential COVID-19 patient.
   - Always put your safety first and of those around you before you attend to the patient.
   - Sanitise your hands before administering first aid.
   - The correct Personal Protective Equipment (PPE) must be worn i.e. gloves, surgical mask and goggles.
   - First aid is administered as per the normal first aid training and response.
   - CPR (if required) must be done with a mouth screen/ guard available in first aid kits.
   - Wash and sanitise your hands after attending to the patient.
   - Sanitising and cleaning of the area and equipment should be done after the response.
   - Following up on the patient and the employee involved in the emergency is vital.

These precautions must be included and practiced in first aid medical drills.

Staff Members: Rotation, shift work and working at home

1. To reduce COVID-19 levels of exposure, operators must try to schedule that the same employees are on the same shift together all the time.
2. All employees that can work remotely must be encouraged to do so.

Travelling to and from work

Operators must provide employees with training and guidance on:

1. How to carry out a COVID-19 symptom check before leaving home for work.
   - If the employee has any of the symptoms listed in the Screening/reporting of symptoms section of this document on page 5 they must not come to work. The employee must seek medical advice from their doctor or phone the NICD hotline - 0800 029 999.
   - If the employee does not have any COVID-19 symptoms and are ready to come to work they must be reminded not to forget their protective gear including a mask, gloves and hand sanitiser.
2. Not to get into a taxi, bus or train if it's full.
3. Wearing a mask at all times.
4. Washing your hands with soap and water and/or sanitise before and after travelling.
5. Keeping a safe social distance from other commuters.
6. Coughing and sneezing into a tissue or elbow.
7. Limiting contact with common surfaces during the commute, remembering not to touch their face, eyes or mouth.
8. Considering other ways of getting to work, such as walking or cycling.
9. Sanitising or wash hands on arrival at work.
10. When leaving work, to remember to repeat the same steps on the way home.

Suppliers and Contractors

1. Operators are instructed to advise all suppliers and contractors that they must follow all the control measures put in place to reduce the transmission of COVID-19 whilst in the facility.
2. When requesting a contractor/supplier to attend the facility, the operators must advise the contractors/supplier to follow the rules of entry into the facility displayed at the entrance.

Returning to training after lockdown

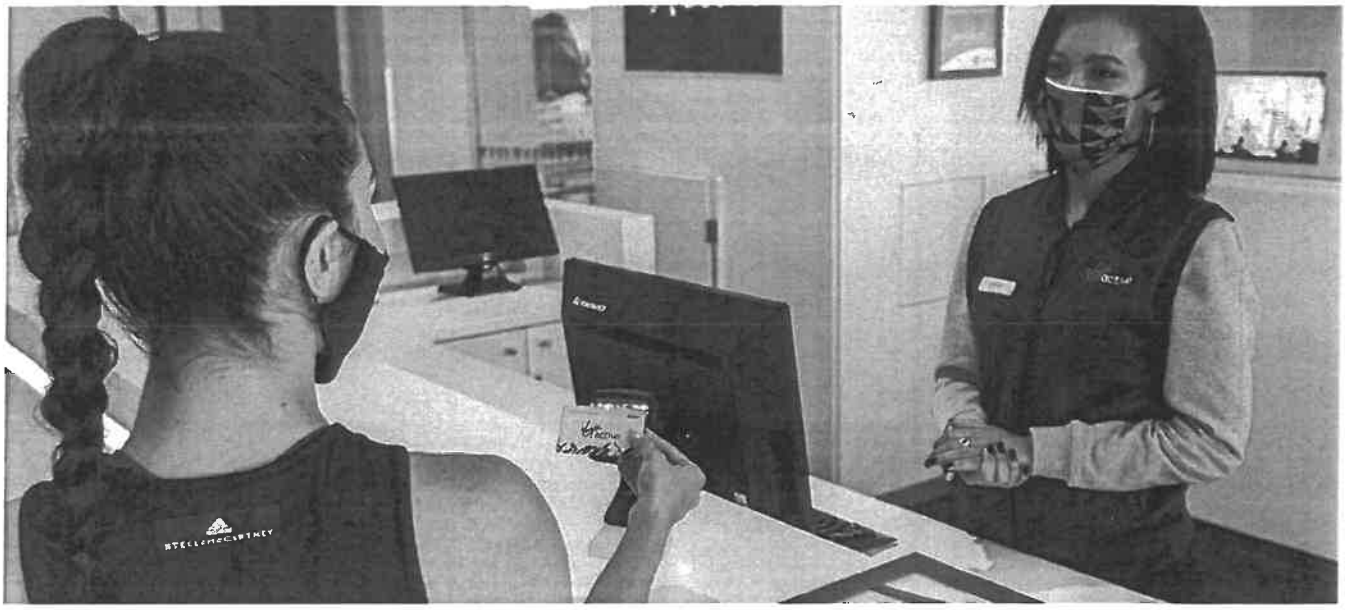
During the lockdown period, most people's ability to exercise would have decreased which would have resulted the decline of fitness and performance levels.

It's important that operators are aware of this and are required to advise all persons wanting to use the facility of the following:

1. It is important to respect that their fitness and normal performance levels may have declined during lockdown. This is called detraining, and it happens when people reduce their training volume and intensity significantly.
2. The degree of detraining is highly individual, and depends on factors such as age, training history, genetics and sport type.
3. Research suggests that total rest (not-training) causes significant on average 3% fitness loss per week. Over 12 weeks of lockdown, this detraining effect means a person might lose about 25%-45% of their original fitness level had you done nothing.
4. Research shows that a person can reduce these losses by about half if they maintain training at even a low level. Therefore, if a person trained at even half their normal volume and intensity, they might expect to lose only 15% to 20%.
5. Because lockdown will have changed the type, volume and intensity of training most people have been able to do, they should expect that it will take some time to adapt and regain that specific fitness, strength and power once a person returns to exercise at a fitness facility.
6. It is important that people give their body the time it needs to regain these fitness levels and physiological adaptations. This process is called retraining.
7. Allow at least one week of retraining time for every two weeks of complete detraining (if a person did nothing). If a person maintained their training to some degree, then they will be able to retrain faster, so they would be able to allow one week of retraining for every three to four weeks of reduced training.
8. This means it would be typical for a person to take between three and six weeks to return to pre-lockdown level of fitness.
9. There is a risk of injury or illness if a person returns to normal training levels too quickly.

Social Distancing

Government social distancing requirements outlined that there should be at least 1.5 meters between people. The following section will provide guidance on how to achieve social distancing in the majority of areas within fitness facilities. Some of the areas listed below will not be applicable to all operators and you are encouraged to focus on the areas that apply to your facility.



Facility Areas

Offices in Fitness Facilities

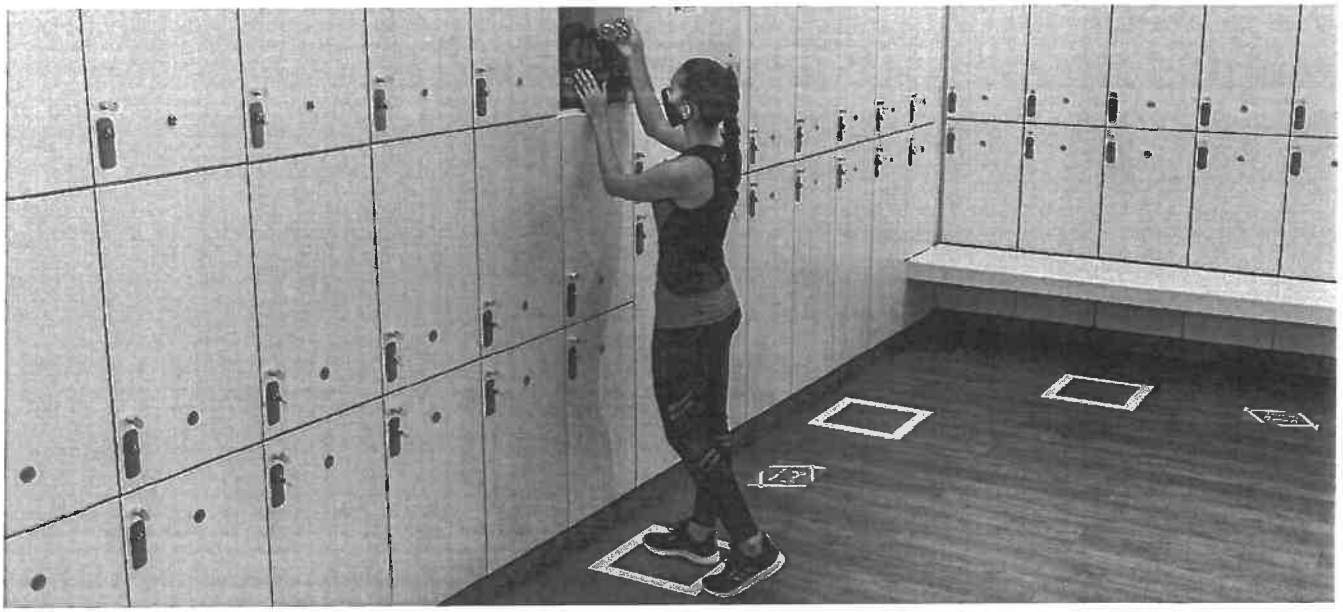
- Remote working must be encouraged.
- If remote working is not possible, it is the operators responsibility to ensure that the space between each workstation is at least 1.5 meters apart.
- All meeting rooms must be closed and tele meetings or outdoor meetings must be encouraged.
- If spacing the workstations is not practicable, physical barriers must be placed between workstations or erected on workstations to form a solid physical barrier between workers while they are working.

Front Entrance, Reception areas

- Social distancing markers must be placed on the floor outside of the facility leading into entrance area at least 1.5 meters apart.
- Employees must stay 1.5 meters apart when working together in this area.
- Employees must stay 1.5 meters away from any person entering the facility at all times.
- Operators should install protective screens or provide employees that work in this area with face shields as all persons coming into the facility are required to pass through this area making it a high traffic point.
- A contactless sign in process should be in place.
- A poster or display screen detailing the social distancing rules within the fitness facility must be positioned at the entrance to the facility.

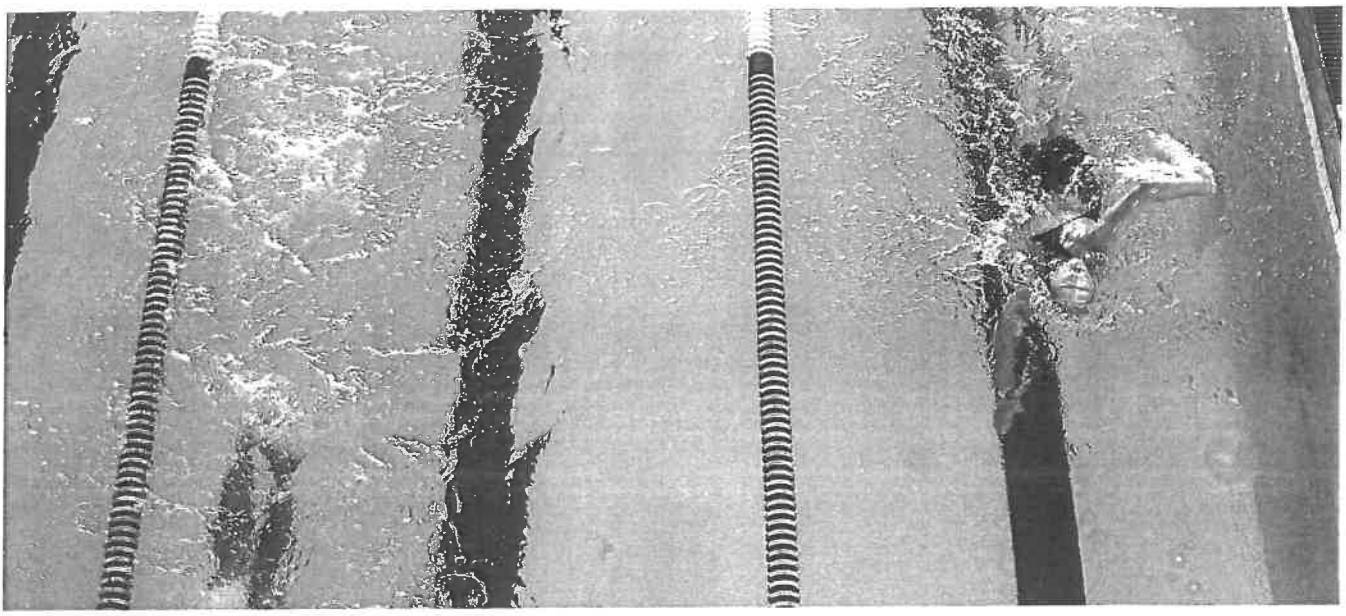
Restaurants, Cafes, Lounges, Relax areas, Workstations

- All food and beverage must follow government guidelines on the operation of restaurants under COVID-19 conditions and must remain closed if stipulated by these regulations.
- All vending machines must be closed.
- Any computers or internet stations available for public use must be removed.
- Social distancing markers must be placed on the floor to indicate distancing requirements.
- A poster or display screen detailing the social distancing rules of the area must be positioned at the entrance to the restaurant.



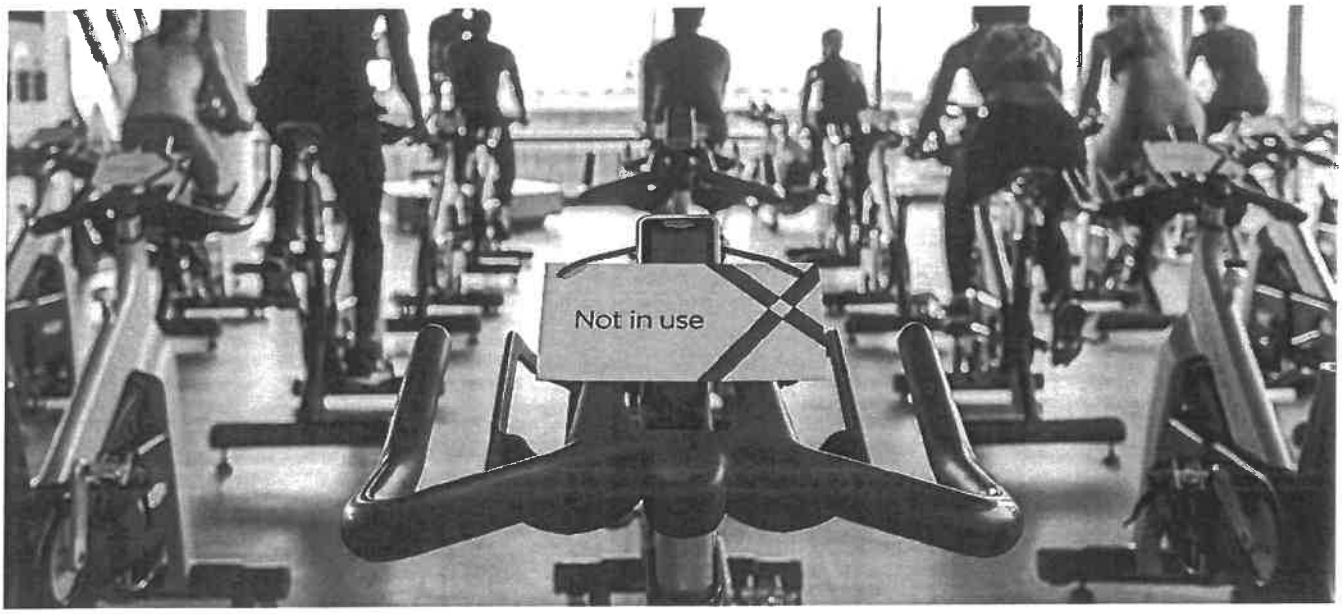
Locker Rooms, Change Rooms, Toilets and Showers

- If government do not require the locker rooms to be closed, then the lockers should be made available 1.5 meters apart.
- Users must be encouraged to shower at home.
- Users must be 1.5 meters apart at all times.
- Social distancing markers must be placed on the floor.
- Saunas and steam rooms must remain closed.
- Every other urinal and basin will be placed out of service.
- Showers must be segregated.



Swimming Pools

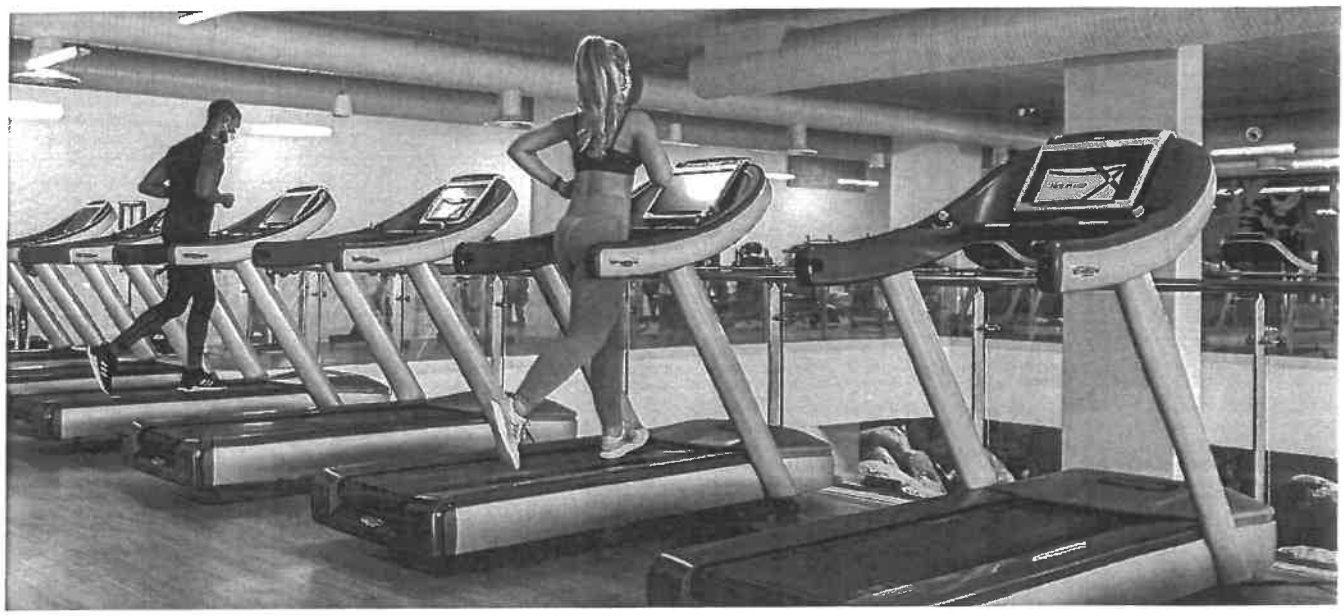
- If government do not require swimming pools to be closed, they can open with social distancing requirements in place.
- All swimmers must rinse themselves off before entering pool area.
- Only two swimmers are to be allowed per lane. Rest intervals should happen on opposite ends of the pool.
- All swimmers must bring and use their own swimming aids.
- No swim goggles or swim caps are be provided by the facility operator, other than those for purchase by a user.
- Swimming squad training can proceed providing 1.5 meter social distancing can be achieved.
- Learn to swim lessons must maintain a 1.5m distance between swimmers and between swimmer and the swim coach.
- Parents may assist their children provided that the parent and their child maintain 1.5m spacing between themselves and other participants and coaches.
- All assisted coaching (e.g. toddlers that need to be held by the coach) is not allowed.
- Aqua classes are allowed provided a 1.5m distance is maintained between participants and between participants and the instructor. The aqua instructor is to actively manage social distancing among class participants.
- A poster or display screen detailing the social distancing rules of the area must be located at the entrance to the pool and on poolside for spectators/parents.



Group Exercise, Cycle, Yoga and Pilates Studios

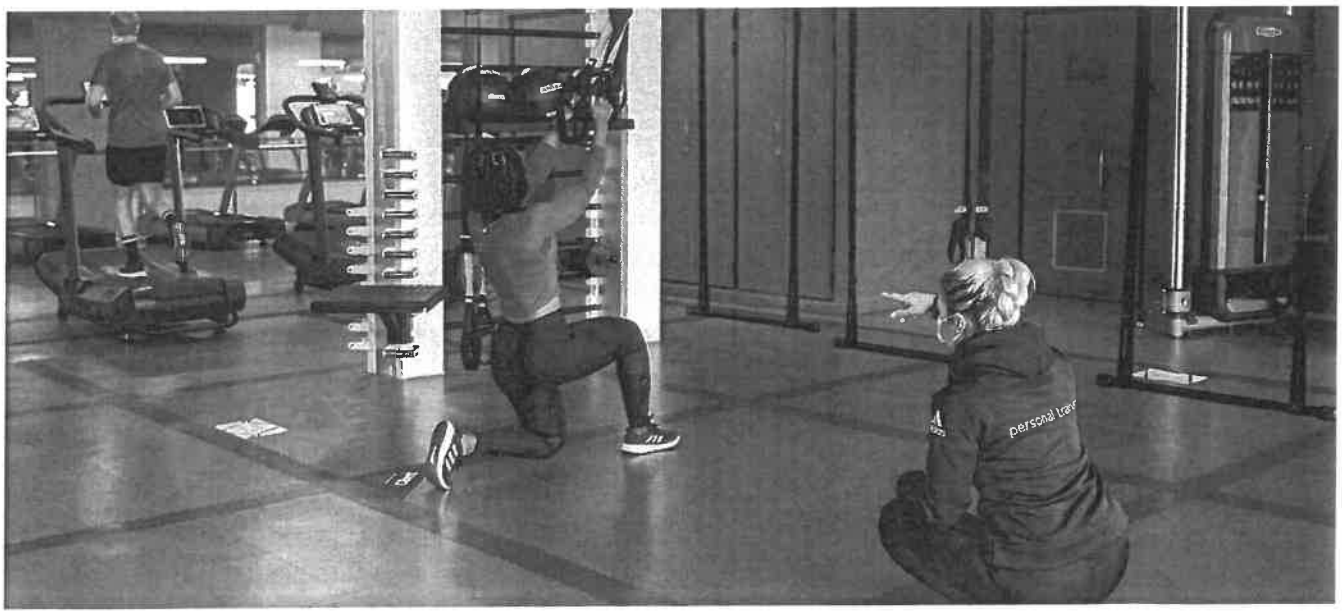
- All persons must be 1.5 meters apart.
- Social distancing markers must be placed on the floor to indicate distancing requirements.
- All exercise Instructors must be trained in the social distancing expectations and must actively manage the social distancing of users.
- A poster or display screen detailing the social distancing rules in the studio must be located at the entrance to the studio.





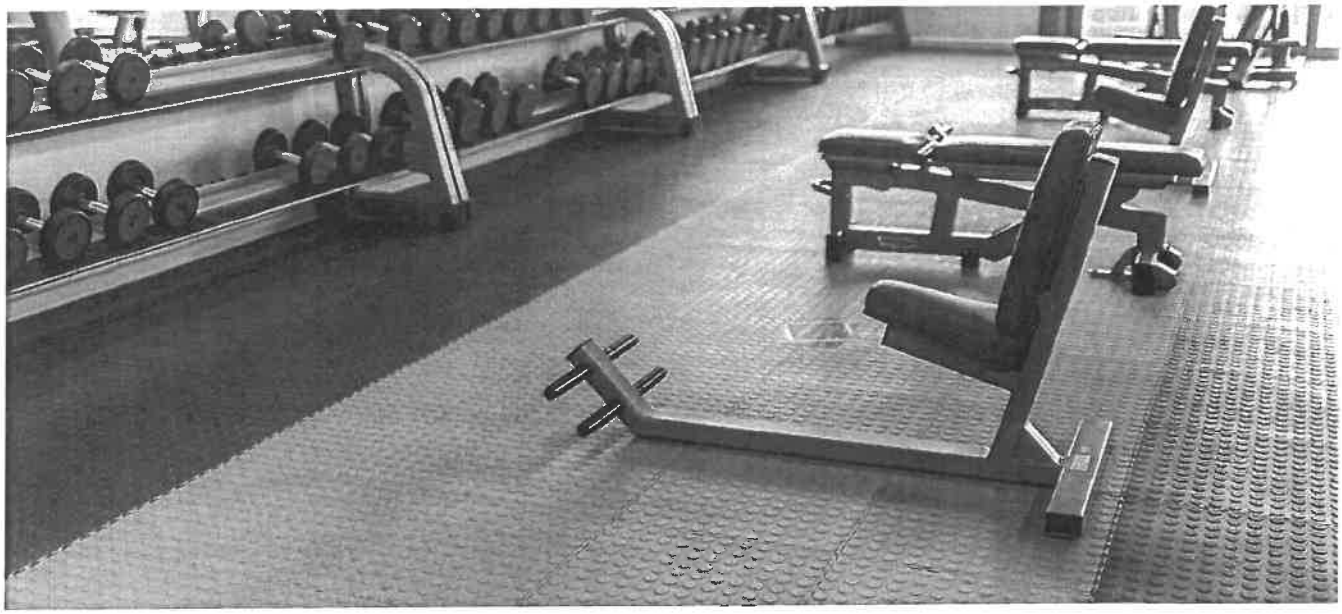
Cardiovascular Equipment Areas – Treadmills, Stationary Bikes, etc.

- Social Distancing markers must be placed on the floor to guide 1.5m spacing.
- All equipment must be 1.5 meters apart.
- If equipment cannot be placed 1.5m apart it must be placed out of use in a manner which prevents members from using the equipment.
- Place social distancing markers on the floor at least 1.5 meters apart indicating where users should stand whilst queuing.
- A poster or display screen detailing the social distancing rules in this area must be located at the entrance to the area.



Resistance and Cable Machine Areas

- Social Distancing markers must be placed on the floor to guide 1.5m spacing.
- All equipment must be 1.5 meters apart.
- If equipment cannot be moved to meeting social distancing requirements, place equipment out of order. Ensure that users are not able to use equipment.
- Place social distancing markers on the floor at least 1.5 meters apart indicating where users should stand whilst queuing.
- A poster or display screen detailing the social distancing requirements in this area must be located at the entrance to the area.



Free Weights Areas

- Social Distancing markers must be placed on the floor to guide 1.5m spacing.
- Equipment and benches must be 1.5 meters apart.
- Spotting assistance is not allowed.
- A poster or display screen detailing the social distancing rules in this area must be located at the entrance to the area.

Functional Training and Stretching Areas

- Social Distancing markers must be placed on the floor to guide 1.5m spacing.
- A poster or display screen detailing the social distancing rules in this area must be located at the entrance to the area.

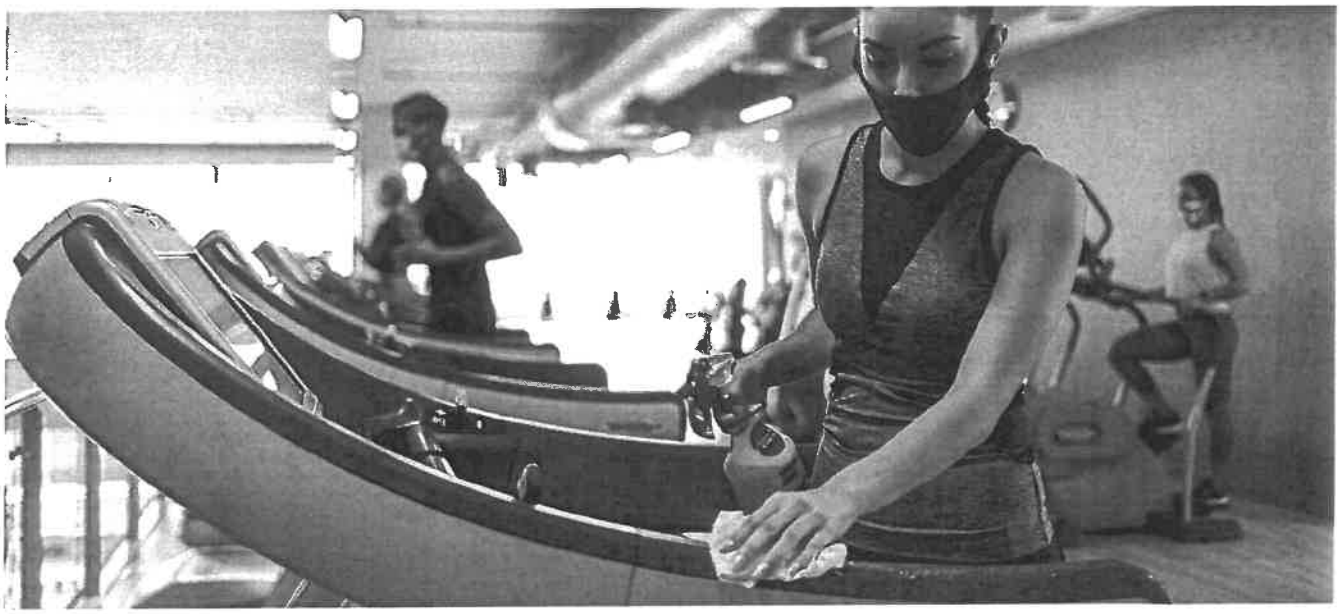
Child Care Facilities

- Operators must follow all government guidance on childcare facilities under COVID-19 conditions and must remain closed if stipulated by these regulations.
- Social distancing markers outside childcare facility entrance at least 1.5m apart.
- Only one family allowed in child care facility reception area at a time.
- No parents are allowed past the child care facility reception area and into the child care facility.
- All activities in the childcare facility must be actively managed to ensure children remain 1.5m apart.
- A poster or display detailing the social distancing rules in this area must be located at the entrance to the area.
- Toys and equipment to be cleaned hourly.
- Use of furniture and equipment:
  - Tables and chairs spaced 1.5 meters apart.
  - Toys – 1 box of toys available per child (avoid sharing, clean after every use).
  - Play equipment - remaining equipment to be used (avoid sharing, cleaned every hour).
  - Play areas - use social distancing markers to keep children playing in their own blocks.
  - Play equipment - remaining equipment to be used (avoid sharing, cleaned every hour).
  - Play areas - use social distancing markers to keep children playing in their own blocks.

Cleaning and Hygiene

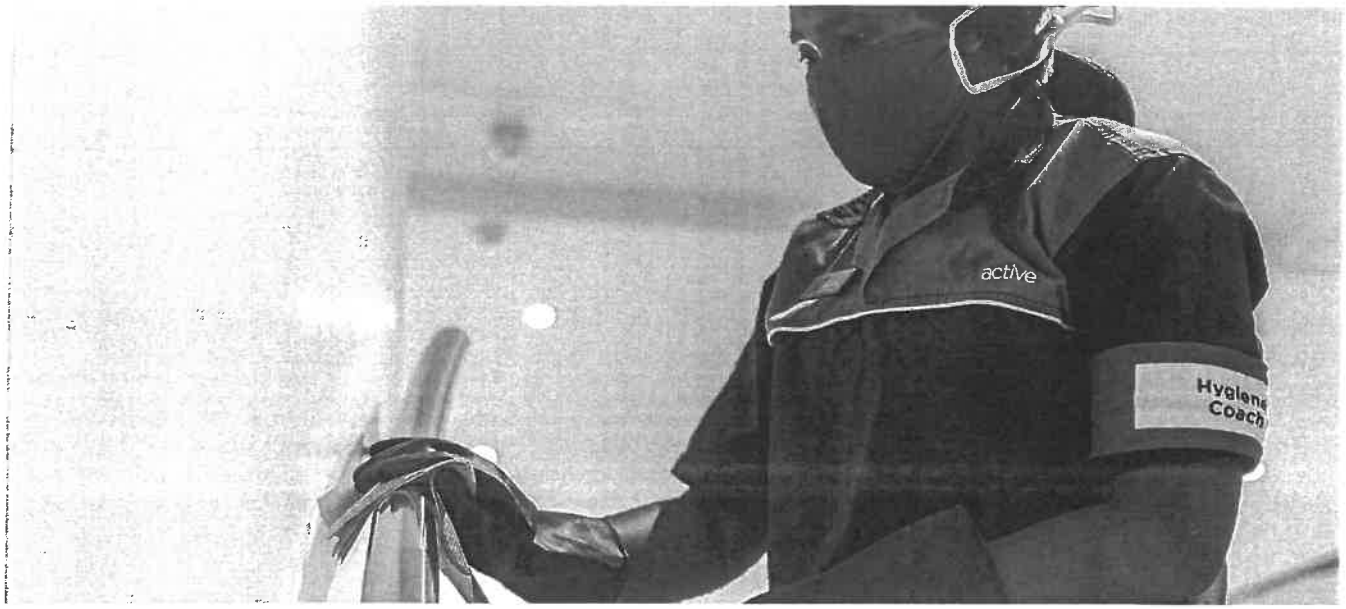
Cleaning

Cleaning helps to remove pathogens on contaminated surfaces and is an essential first step in any disinfection process. The following section will provide guidance on how to effectively clean the majority of areas within fitness facilities. Some of the areas listed below will not be applicable to all operators and you are encouraged to focus on the areas that apply to your facility.



All Fitness facility operators must:

1. Employ competent cleaners who have been trained to clean and dispose of waste under COVID-19 conditions.
2. Use chemicals with anti-viral properties.
3. Have detailed and recorded cleaning protocols in place throughout the day.
4. Focus on high touch points, hard surfaces and all fitness equipment frequently throughout the day.
5. Keep adequate supplies of:
   - Cleaning equipment - Mops, cleaning cloths, scrubbers, buckets and sponges.
   - Cleaning materials - Cleaning detergent, disinfectant.
   - PPE for cleaning employees - Face masks (FFP2), gloves, aprons, protective eyewear.
6. Ensure that cleaners wear the correct PPE at all times.
7. Give extra focus to all areas such as toilets, common areas, door handles, locker handles and shared electronic equipment, ensuring that they are frequently cleaned and disinfected throughout the day.
8. Ask all users to clean fitness and other equipment before and after use with readily available disinfectant sprays and paper towels provided by the facility operator.
9. Provide sanitisation wipes located in areas with high touch points such as vending machines, water fountains and vanity units, for users to apply before and after use.



Offices in Fitness Facilities

- All office employees must clean their workstation including desk, mouse, screens and keyboard before they leave the office every day using chemicals with anti-viral properties.
- A clear desk policy must be in operation.
- Usual cleaning procedures throughout the day and the end of the day must continue.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.

Restaurants, Cafes, Lounges, Relax areas, Workstations

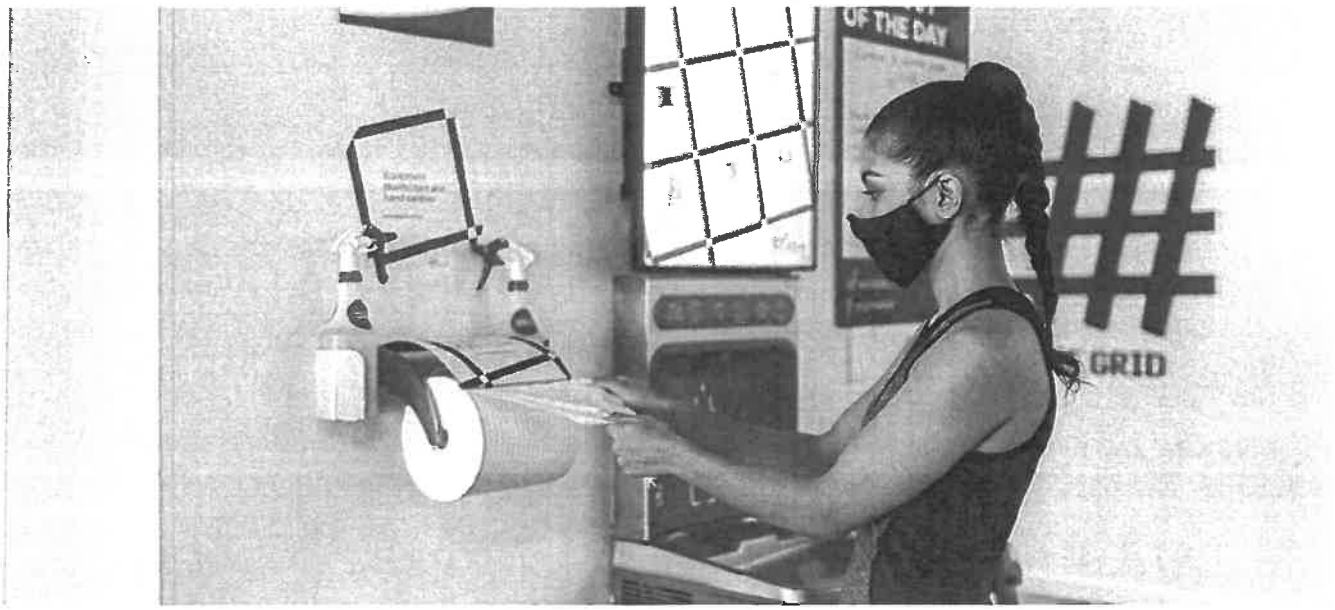
- Any pieces of equipment that are difficult to clean must be removed.
- Communal newspapers must be removed.
- Water fountains must be placed out of use.
- No personal cups will be used for coffee, water or any other beverage.
- Milk and water jugs must be removed.
- High chairs must be cleaned after each use.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.

Locker Rooms, Change Rooms, Toilets and Showers

- Remove any facility supplying beauty and grooming products to limit touch points.
- Remove all facility supplying amenities such as cotton pads and ear buds.
- Remove all facility supplying sweat towels and robes.
- Wipes must be made available for high touchpoint areas such as hairdryers and straighteners.
- Correct hand washing guidance posters should be placed near the basins.
- A poster or display screen detailing the social distancing rules of the area must be visible at the entrance, and inside the locker room and wet areas.
- Soap must be available in the showers and next to the basins.
- Paper towels or contactless hand dryers must be provided for proper hand drying.
- There are to be no reusable cloth towels for hand drying.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.

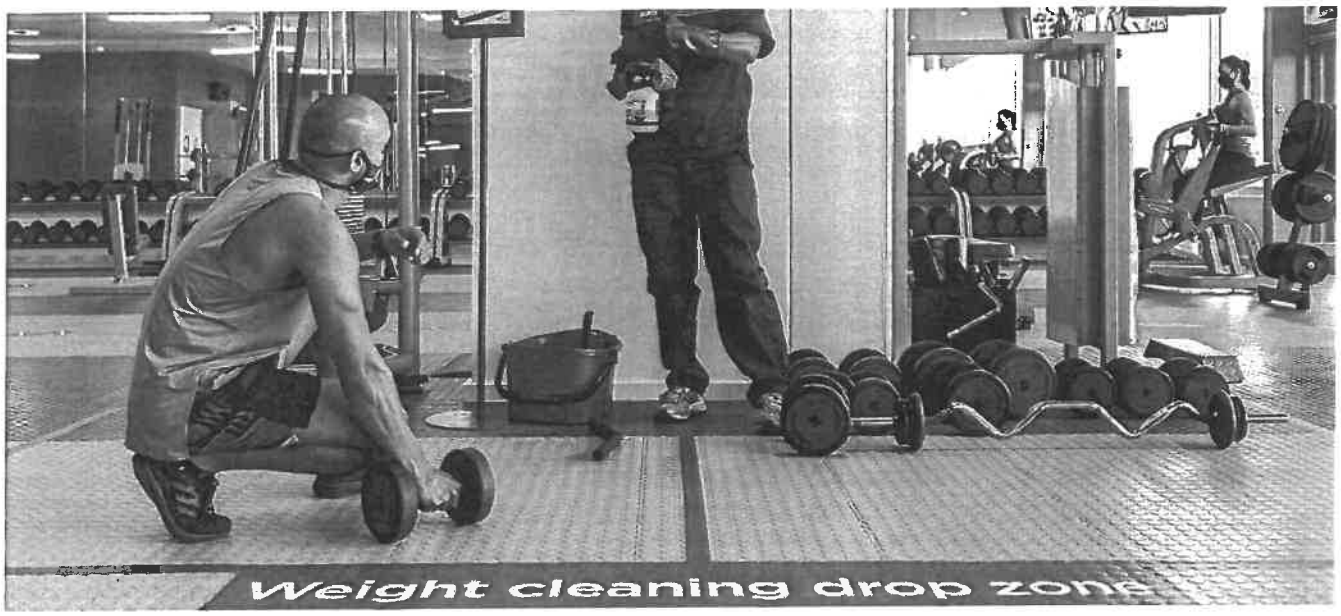
Swimming Pools

- Remove all pieces of equipment that are difficult to clean from the swimming pool area.
- Ice machines must be taken out of use.
- Pool loungers must be taken out of use.
- No facility supplied equipment such as pull buoys and kickboards are to be provided. Users must bring their own if required.
- Lane ropes are not to be taken out of the pool as they become a high touch point if they are continually moved.
- When rescue equipment is used, it must be disinfected immediately after.
- In swimming lessons, if equipment is used it must be cleaned after each use. Where possible, ask the swimmer to bring their own equipment.
- In swimming lessons, there is to be no sharing of equipment between swimmers.
- No facility supplied loan goggles and swimming caps is allowed. Users must provide their own.
- In swimming lessons, handheld devices must be sanitised after every use.
- In swimming lessons, all children must wash their hands before and after every lesson.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.



Group Exercise, Cycle, Yoga and Pilates Studios

- Any pieces of equipment that are difficult to clean must be removed e.g. boxing gloves and some yoga equipment.
- After every Group Exercise class the studio and equipment must be cleaned.
- No sweat towels are allowed in any studio.
- No sharing of equipment in classes is allowed.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.



Gym Floor – Cardiovascular, Free Weights, Functional and Resistance Machine Areas

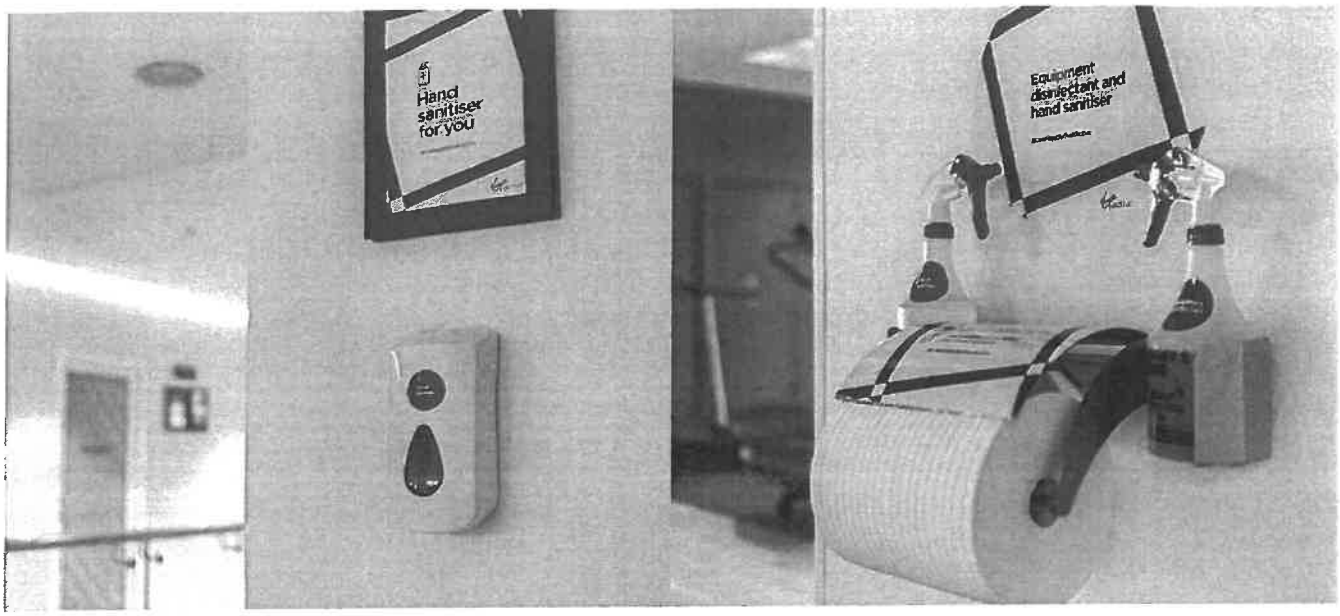
- Any pieces of equipment that are difficult to clean must be removed.
- Water fountains will only be used for filling bottles.
- In the free weights area, a weights drop off & clean zone must be implemented. A cleaner must clean all dumbbells and return them to the rack.
- No sweat towels are allowed on the gym floor.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.

Child Care

- Any pieces of equipment that are difficult to clean must be removed.
- No snacks are allowed.
- All children must wash their hands upon arrival and before leaving the area.
- Children must go to the bathroom one at a time (assisted by an employee where required).
- When changing nappies or feeding babies from bottles, employees must wear PPE. This includes a face mask, disposable apron and disposable gloves. PPE must be changed after each session of care.
- Childrens' coats, bags and other belongings must be kept in their parent's locker. Exceptions to this would include nappy bags and medication.
- All soft play items and other soft toys must be removed from play areas and temporarily stored.
- All other toys, must be used on a rotation basis. When these toys are in use, they must be cleaned periodically throughout the day or depending on usage.
- A poster or display screen detailing the cleaning rules in this area must be located at the entrance to the area.

Waste Disposal

- All suspected contaminated materials need to be disposed of adhering to the National Environmental Management Act.
- All bins must have a plastic bin liner bag which can be tied at the top.
- All disposable tissues, paper towels and cleaning materials are to be placed in a bin immediately after use and not left on surfaces.
- Regular emptying of bins inside the workplace must take place to avoid overflow.
- When emptying bins, staff should wear gloves and dispose of the gloves into a bin after use.



Hygiene

Frequent hand washing, or hand cleaning with sanitiser, is the first line of defence in preventing COVID-19 infection. It's important that operators provide adequate means for any person while in a fitness facility to clean their hands regularly.

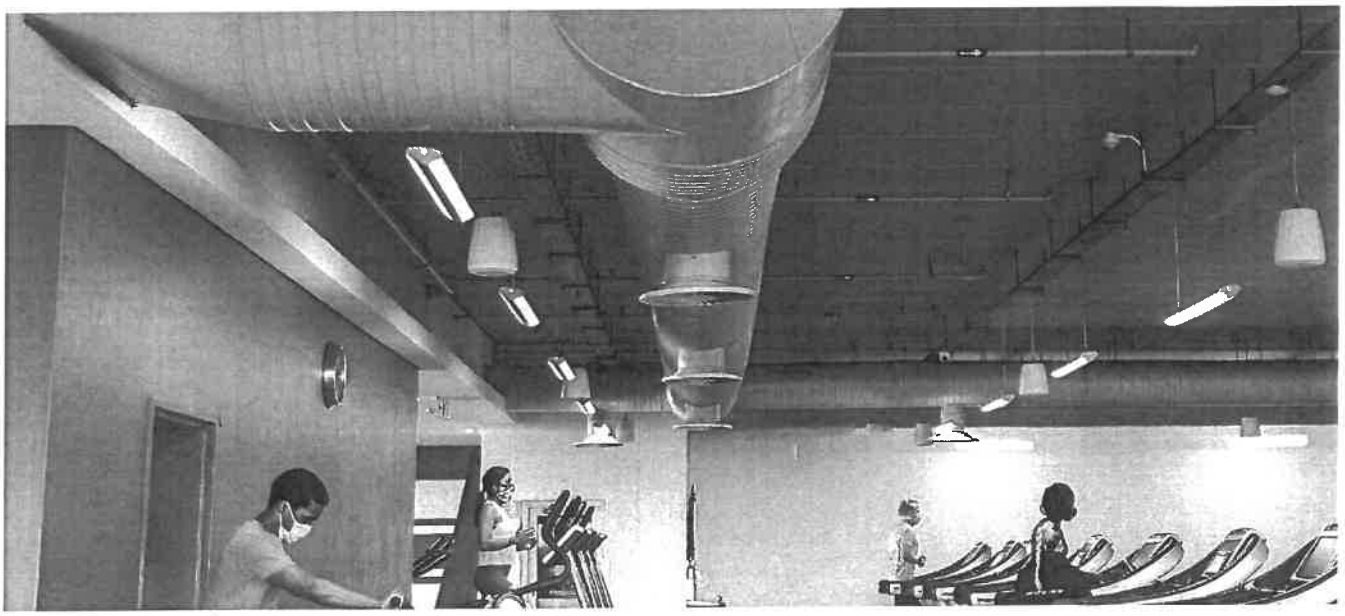
1. Operators must keep adequate supplies of:
   - Soap.
   - Hand sanitiser.
   - Paper Towels.
   - Disinfectant Spray.
   - Cleaning / Sanitisation Wipes.
2. Operators must provide hand sanitisers in the following areas of facility:
   - At the front entrance.
   - In close proximity to the free weights area.
   - In close proximity to the cardiovascular area.
   - In close proximity to studios.
   - At the entrance to the locker rooms, change rooms and toilets.
   - In child care areas.
3. A sanitisation station must be available at various locations around the facility and must consist of:
   - Paper towel.
   - Paper towel holder.
   - Disinfectant spray.
   - A bin to dispose the paper towel in.

   Sanitisation stations are for users to wipe down fitness equipment and surfaces before or after use.
4. Any employee who works away from the facility, other than at home, must be provided with an adequate supply of hand sanitiser.
5. All employees interacting with any person are requested to sanitize their hands between each interaction.

Ventilation

It is important that all fitness facilities are well ventilated with fresh air to reduce the COVID-19 viral load.

1. In facilities that have limited mechanical ventilation systems in place they must open windows and doors, without compromising security, to increase fresh air supply.
2. Facilities that have an operational mechanical ventilation system in place must:
   - Increase the fresh air intake as far as possible.
   - Decrease air recirculation as far as possible.
   - Have a minimum of 12-15 air changes per hour in the lockers rooms, change rooms, toilets and showers.
   - Have a minimum of 15-18 air changes per hour in the main areas of the facility.
   - Have a minimum of 18-20 air changes per hour in the studio area of the facility.
3. The filters on the mechanical ventilation system must be cleaned and replaced in accordance with the manufacturer's instructions by a competent person.
4. If the ventilation system is not in good working condition, the facility must be closed immediately and if the ventilation system is not working in a confined area like a studio, the scheduled class timetable must be cancelled until the system is adequately repaired.



Swimming Pools

There is no evidence that COVID-19 can be spread to people through the water in pools, spa pools, or water playgrounds. Additionally, proper operation of swimming pools and disinfection of the water (with chlorine or bromine) should inactivate COVID-19.

1. Swimming pool water quality must be maintained by using Calcium Hypochlorite, Bromine, Sodium Hypochlorite (salt-based chlorine production), Hydrochloric Acid, flocculent, ultraviolet light or Sodium Bicarbonate or any combination thereof.
2. For the safety of users, the chemical levels in swimming pools must be tested and recorded regularly throughout the day to ensure that the correct disinfection levels are being maintained.

Towels

1. Towel services can continue, provided that the employees coming into contact with the towels, follows good hygiene protocols such as wearing of gloves, suitable masks as indicated by the risk assessment and washing and sanitising hands post handling the towels.
2. Towels should also be washed and dried following the instructions provided by the manufacture.
3. Towels are only to be used in the changing rooms and must not be taken out of the change rooms.
4. No sweat or other towels must be allowed anywhere in the facility other than in the changing rooms. Users must use facility provided paper towels to clean and disinfect equipment and surfaces before and after use.

Safe Work Practices

Developing a COVID-19 opening plan

How to develop a COVID-19 opening plan:

Walk through all areas in the fitness facility.

Write down how you would:

1. Health screen any person entering the facility.
2. Collect and store time, date and personal contact information of any person entering the facility.
3. Apply social distancing control measures for each area of the facility.
4. Clean each area and all of the equipment in that area throughout the day.
5. Provide hygiene supplies for users and staff members so that they can regularly clean their hands and the equipment they use.
6. Train your staff in the control measures in the club they you are putting in place to keep them safe. Train employees on what they need to do before coming to work, on their way to work and when they get to the fitness facility. Make sure you cover the following topics:
   - Your COVID-19 opening plan.
   - Personal Hygiene.
   - How to get to and from work safely.
   - Hygiene around the facility.
   - Social Distancing.
   - How to deal with user behaviour toward new control measures in the facility.
   - This document.
7. Communicate to users in the most convenient way possible - on your website, via social media, posters, about the control measures that you are putting in place to keep them safe. Tell them they need to stick to the rules when entering the club and using each area, for the safety of themselves, other users and the fitness facilities employees.
8. Continually improve your control measures by speaking to your employees and the facility users, while keeping up to date with what other operators in the industry are doing, and the latest scientific information on control measure to prevent COVID-19 infection.
9. Check that the control measures are in place every day throughout the facility. For example, pre-opening social distancing checks, cleaning check lists, hygiene supply check lists, etc.

Use the general and specific guidance provided in this framework to help you.

Developing a COVID-19 opening plan

Make sure you keep an easily accessible record of your COVID-19 opening plan containing all of the points listed above in points 1-9.

If you employ any staff you are required by law (COVID-19 Occupational Health and Safety Regulations 2020) to carry out a risk assessment. Use this link for a step by step guide on how to complete a COVID-19 risk assessment: https://www.saiosh.co.za/news/506598/COVID-19-Step-by-Step-Risk-Assessment-Template-.htm. If you are not competent to complete a risk assessment, seek professional advice from a qualified safety practitioner.

Reporting and Investigation of Incidents

If an employee has been diagnosed with COVID-19, it must be reported to the Department of Health and the Department of Employment and Labour and an investigation to identify the possible control measure failure must take place.

Government Inspections

The Department of Health and the Department of Labour are mandated to conduct site inspections to measure compliance to the COVID-19 Occupational Health and Safety Regulations 2020.

Inspectors may visit your facility. They are here to help you improve the control measures for your facility and help you comply with the regulations.

Always:

- Request positive identification from the Government Inspector i.e. ID or badge.
- Accompany the Government Inspector throughout the inspection.
- Provide all reasonable assistance to the inspector in fulfilling their mandate.
- Request an official report from the Inspector (if there are no findings, it must be stated on the report).
- Ask for advice on any non-compliance issues.

Presentation to the National Coronavirus Command Council

9 July

Salim S. Abdool Karim, *FRS*

Chair: Ministerial Advisory Group on Covid-19
Member: Africa Task Force for Coronavirus
Member: Lancet Commission on Covid-19
Director: CAPRISA – Centre for the AIDS Program of Research in South Africa
CAPRISA Professor in Global Health: Columbia University
Adjunct Professor of Immunology and Infectious Diseases: Harvard University
Adjunct Professor of Medicine: Cornell University
Pro Vice-Chancellor (Research): University of KwaZulu-Natal

Ministerial Advisory Committee for Covid-19



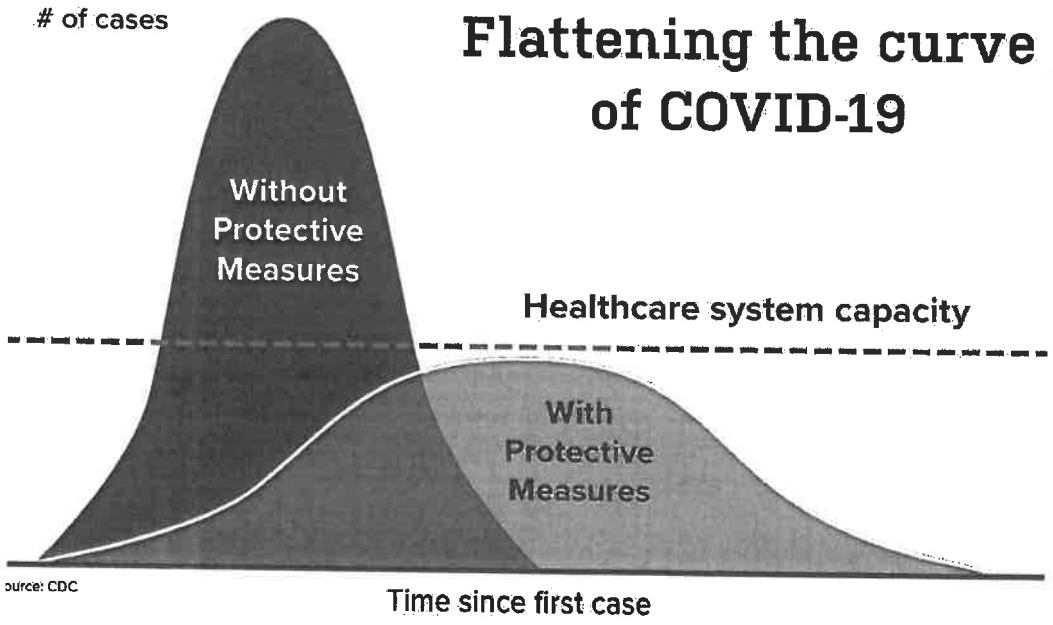
Secretariat

Many divergent views were expressed by the MAC on the issues covered here – I have tried to capture some of the diversity of views

Information requested from the MAC

- Some new information on Covid-19
- Definition of a hotspot
- Advice against level 4 or 5 lockdown
- Consider additional steps to enhance prevention without raising lockdown level
- Conclusions

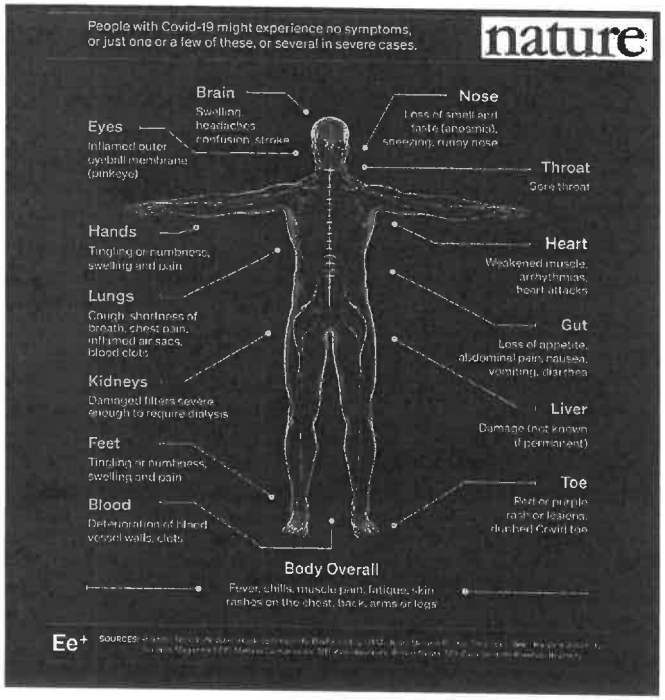
Primary goal of South African Covid-19 response is "flattening the curve"



SARS-CoV-2 – new pathologies discovered

Every Covid-19 Symptom We Know About Right Now, From Head to Toe

The most perplexing things about a disease that has proved vexing, deadly, and 'unprecedented in many ways'





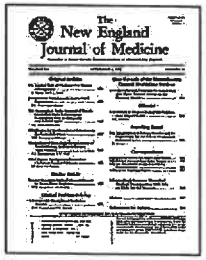
New-Onset Diabetes in Covid-19

TO THE EDITOR: There is a bidirectional relation- to inform the immediate clinical care, follow-up,



Diabetic ketoacidosis precipitated by Covid-19 in a patient with newly diagnosed diabetes mellitus

Ying Jie Chee[a,*], *Shereen Jia Huey Ng*[a,1], *Ester Yeoh*[a,b,2]



Multisystem Inflammatory Syndrome in U.S. Children and Adolescents

L.R. Feldstein, E.B. Rose, S.M. Horwitz, J.P. Collins, M.M. Newhams, M.B.F. Son, J.W. Newburger, L.C. Kleinman, S.M. Heidemann, A.A. Martin, A.R. Singh, S. Li, K.M. Tarquinio, P. Jaggi, M.E. Oster, S.P. Zackai, J. Gillen, A.J. Ratner, R.F. Walsh, J.C. Fitzgerald, M.A. Keenaghan, H. Alharash, S. Doymaz, K.N. Clouser, J.S. Giuliano, Jr., A. Gupta, R.M. Parker, A.B. Maddux, V. Havalad, S. Ramsingh, H. Bukulmez, T.T. Bradford, L.S. Smith, M.W. Tenforde, C.L. Carroll, B.J. Riggs, S.J. Gertz, A. Daube, A. Lansell, A. Coronado Munoz, C.V. Hobbs, K.L. Marohn, N.B. Halasa, M.M. Patel, and A.G. Randolph, for the Overcoming COVID-19 Investigators and the CDC COVID-19 Response Team*

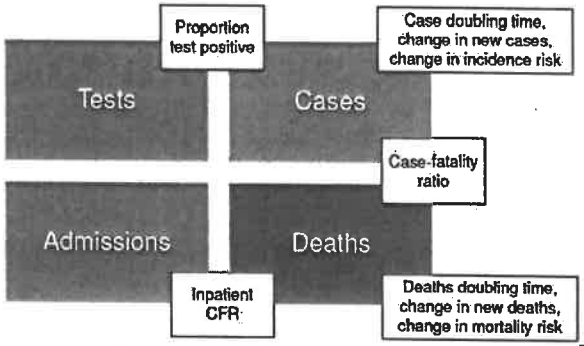
New data on the impact of SARS-CoV-2 on economies

Country	GDP (2019) (US$ million)	GDP growth rate (2019)	Estimated GDP growth rate (2020)
United States	21,439,453	+2.3%	**-5.9%**
China	14,140,163	+6.1%	**+1.2%**
South Korea	1,629,532	+2.0%	**-1.2%**
Australia	1,376,255	+1.9%	**-6.7%**
United Kingdom	2,743,586	+1.4%	**-6.5%**
Sweden	528,929	+1.2%	**-6.8%**
Nigeria	446,543	+2.2%	**-3.4%**
South Africa	358,839	+0.2%	**-5.8%**

Sources: GDP estimates: https://en.wikipedia.org/wiki/List_of_countries_by_GDP_(nominal); GDP growth rate: https://www.statista.com/

Definition of a hotspot

- Cases, hospitalisations and deaths say different things as indicators
- Admissions (bed occupancy) were considered most relevant and aligned well with the flattening the curve goal



*Ideally derived from a repeated well-designed random population surveys

- Data being collected at provincial level – collated by NDoH at CSIR - data quality & analysis not clear
- Threshold to be high (?95%) – usual occupancy >65%
- Limitations – need staffed beds, private vs public beds

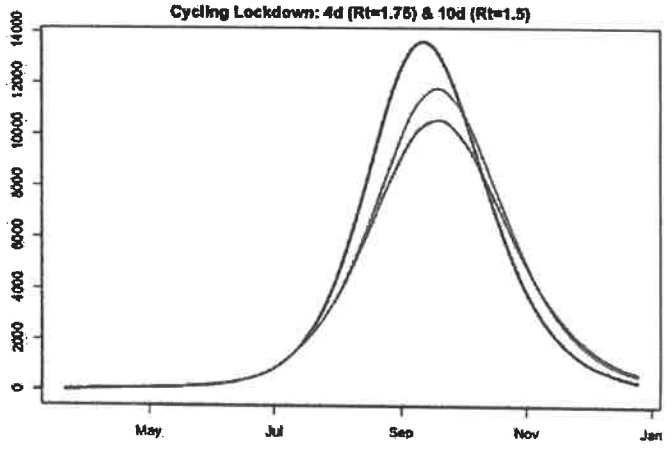
Advice against level 4 or 5 lockdown

- Prospects of R_0<1 low
- Impact on the economy & other health services
- At 147 infections/million – > when done by others

Note: Differing MAC member's views: Some said go back to level 4/5 lockdown & others to level 1 with no restrictions

- *What about cyclic lockdowns?*
- Modelling of a cyclic lockdown revealed minimal benefit
- Slightly lower admissions for substantial economic cost

Gauteng



Base (black), Equal Compliance (Red), Decreasing Compliance (Green)

Consider additional steps to enhance prevention without raising lockdown level

- Actively promote behaviour change
- Enforcement (non-police) of masks in shops and taxi ranks
- Mask wearing & physical distancing incentives (e.g. prizes)
- Promote natural ventilation through open windows
- Particularly important – Open window jammers in taxis
- Hotspots: Reduce risk of transmission through roll-backs on places of worship, cinemas and casinos, restaurants (e.g. reduce 50 to 20)
- Hotspots: Re-instate curfew to ↓ accidents/trauma to ↓ bed demand

Additional steps: Possible alcohol restrictions

- **Option 1: Alcohol ban similar to level 4/5 alcohol restrictions**
  - *Over next 8-weeks, models estimate alcohol admissions will take up 189,677 days in general wards and 17,714 ICU-bed days*
  - *A ban may reduce this by 20-30%*
- **Option 2: Partial alcohol restrictions (difficult to enforce)**
  - *Ban sale of large containers of alcohol, Set purchase limits, Reduce drunk driving alcohol limit, etc*
- **Some MAC members do not think the MAC is the appropriate body to advise on alcohol and some had reservations in restricting alcohol**

Conclusion

- SA is in "*Damned if you do & damned if you don't*" period
- Expectation of action in provinces where cases rising
- But concern that increasing lockdown levels is not economically viable & may not flatten the curve similar to the initial lockdown
- Hence, advice against increasing to level 4 or 5 lockdown
- Advice on potential steps to implement during level 3 including some roll-back steps
- MAC's limited expertise in behaviour change - contribution of Socio-behavioural MAC a higher priority at this stage of the epidemic

Alcohol recommendations

Background

Over the past 100+ days of the lockdown in South Africa, there has been an exponential rise in positive cases of Covid-19: from 116 on 18 March to 196,750 on 5 July. During levels 4 and 5 of the lockdown, which included a ban on the sales of liquor from both on and off-consumption outlets and substantial restrictions on movement/work, there was a 60%-70% reduction in hospital visits and admissions related to trauma (Parry et al., under review). The period of "lockdown light" from 19 to 26 March comprised of restrictions on the operating hours and days of the week when sale of alcohol at on- and off-consumption outlets was permitted as well as a restriction on the number of patrons allowed at on-consumption outlets selling alcohol. A quick review of preliminary data for the weekend of 21 and 22 March 2020 showed a 25%-50% drop in transport emergencies dealt with by ER24's contact centre, a drop in assaults and stabbings recorded by Rescue 786 Ambulance Services, and a decline in surgical and medical emergency cases at Johannesburg's Chris Baragwanath Hospital outside Soweto (de Wet, 2020).

Following the easing of restrictions to Level 3 on 1 June 2020 a noticeable surge in trauma-related hospital visits has been observed. This has been anecdotally attributed to easing of restrictions related to the sale and distribution of alcohol. Calls are now being made to re-impose alcohol restrictions with claims that this would stem trauma-related hospital visits, thereby freeing health services, staff and wards, for the care of Covid-19 patients.

This raises the following questions:

1. What would be the effect of re-imposing a ban on liquor sales during Level 3 lockdown on trauma-related hospital visits and admissions?
2. What would be the effect of placing tighter restrictions on alcohol access as opposed to a ban on liquor sales in terms of reducing burden on public health care system and trauma admissions?

The effect of a ban on liquor sales on trauma-related visits during the Level 3 lockdown

Table 1 below sets out a process whereby the team estimated the number of trauma unit visits that could be averted if a ban on liquor sales is implemented.

Table 1: Modelling the effect of a reduction in trauma unit presentations in Level 3 lockdown following imposition on of a ban on liquor sales

				Supporting information
	Multiplier	Number		
Number of trauma unit presentations per year in SA				
Number of trauma presentations per year across 356+ secondary & tertiary public hospitals (1999)		1,511,040		Matzopoulos et al., 2006
Estimated number in 2020 across secondary & tertiary public hospitals	1.47	2,221,229		using 47% increase in mid-year population estimates from persons 15+ from StatsSA (StatsSA 1999, 2019)
Estimates per week				
Estimated trauma presentations per week before lockdown	0.019	42,716		Roughly 120 per hospital per week on average. Roughly double that at Baragwanath & ~180 at Charlotte Maxeke
Estimated trauma presentations in Level 3 per week (80% of pre lockdown trauma presentations) compared to pre-lockdown	0.8	34,173		91% of pre-lockdown in WC across 5 hospitals (WC Department of Health, 2020). 75% from Mahatma Gandhi, KZN
Estimated alcohol-relate trauma presentations Level 3	0.5	17,086		Expert opinion - this is maximum we could save per week if no alcohol-related trauma presentations. Of these 50% are alcohol (not 60%, because nightclubs, bars, shebeens where violence is higher are closed, & only selling Mon-Thurs, & people have less money). Currently in L3 Bara: 60% at weekends, 50%-60% overall at Charlotte Maxeke
So what % of ~17,000 would disappear if alcohol sales stopped as in L4 & L5?				
1st week after instituting a ban on liquor sales in Level 3 lockdown	0.2	3,417		
2nd week	0.3	5,126		Expert opinion: In WC (5 hospitals) with drop from pre-lockdown to Level 5 we saw a 49% drop in trauma presentations. In other sites more, up to 70%, but there were many more restrictions on movement, work, exercise, less vehicles on roads so initial drop will be less. Will also be less trauma presentations reduced inititially as people would have stockpiled, including entrepreneurs (but they will sell at a premium so that will reduce consumption).
3rd week	0.4	6,835		
4th & subsequent weeks	0.4	6,835		
Est. saving in alcohol-related trauma presentations over 4 weeks: 22,212 trauma presentations; over 8 weeks: 49,550				

In comparison to the drop in alcohol-related trauma that occurred with the imposition of a temporary ban on alcohol sales at the beginning of lockdown Level 5 (60%-70%), the effect of the ban during lockdown Level 3 is likely to be somewhat less as a result of people and businesses stockpiling alcohol, in some cases for resale for greater profit. In addition, people have learned to improvise and brew their own alcohol. The longer the duration of the ban the greater the impact.

Using the model demonstrated in Table 1 above, it is estimated that a ban could achieve a reduction of approximately 3,400 alcohol-related trauma presentations across public secondary and tertiary hospitals by the end of the first week following a ban on liquor sales (that is, an estimated 10% reduction in Level 3 weekly trauma presentations, or 20% of the alcohol-related trauma

presentations), levelling out to a maximum reduction of approximately 6,800 alcohol-related trauma presentations by the end of the third week (or 20% of all trauma admissions/40% of alcohol-related trauma presentations).

This is likely to have a substantial impact on reducing the burden on staff in trauma units, the demand for inpatient beds, ICU facilities and ventilation capacity.

In many cases such patients place a strain on medical care for extended periods. For example, 2% of stab-related admissions (a common trauma associated with alcohol use) require admission to the ICU for an average of 5 days. The impact of blunt force trauma is greater. Of 72% requiring a hospital admission, 25% are admitted to the ICU for an average of 9 days.

A trauma patient presenting to a health care facility and not requiring admission, contributes to overcrowding, and therefore increasing the risk of transmission of Covid-19 between patients and staff in the emergency centres. It is worth noting that trauma patients requiring surgery consume resources such as theatre time, and skilled staff such as anaesthetist, two surgeons, an anaesthetic nurse, scrub sister and floor nurse. Such staff can potentially be deployed to other areas of need in the hospital. Poly-trauma patients frequently require prolonged hospitalisation and extended rehabilitation often exceeding 4-weeks. We considered the percentage of cases admitted to general wards and to ICU units and the length of stay in general wards and ICU units for six different injury types: blunt force trauma, burns, sharp force trauma, road collisions, gunshots, self-harm and falls. Using the median values across these six categories we estimated that the 49,550 cases from Table 1 would, over 8-weeks, equate to 189,677 days spent in general wards and 17,714 days of ICU bed occupancy. These cases could potentially be averted through an alcohol sales ban.

In general, alcohol use is expected to reduce adherence to non-pharmacological methods of reducing the transmission of SARS CoV 2 such as physical distancing, hand sanitation and use of masks within the social setting. In addition, hospitals are considered high risk areas for exposure to COVID. By limiting alcohol-related hospital visits/admissions we are limiting exposure to and transmission of SARS CoV 2. A ban on alcohol sales will also have an impact in terms of reducing the burden on primary care and private facilities, but we were unable to quantify this at this time due to lack of data.

Is there an alternative to a ban on liquor sales in terms of reducing burden on public health care system and especially trauma admissions?

An alternative to a complete ban on alcohol sales to reduce alcohol-related trauma admissions is to implement one or more less restrictive alcohol control interventions mostly aimed at reducing the availability of alcohol. Many of these and other interventions noted below have been identified as evidence-based strategies by the WHO. In contrast to a single intervention like a ban on alcohol sales (or substantially increasing excise taxes), a combination of strategies such as these is more challenging to implement, and will have lesser impact even if used in combination. However, from a strategic point of view, it might be useful to consider taking such an approach to prevent push-back from the public and the liquor industry and associated businesses. It might also make it easier to defend legal challenges should they arise at a later stage if it is decided to still go ahead with a ban on liquor sales as government will be able to demonstrate that it implemented less intrusive options first which didn't have the desired impact.

Table 3. Strategies other than a ban on liquor sales to consider in Level 3 to reduce alcohol-related trauma presentations

Strategy		Rationale and approach	Challenges
Limit Availability	Limit off-consumption times for outlets with off-consumption licenses (Tue-Thu: 09:00-17:00) #	4 days to 3 will further reduce relatively painlessly for consumers.	Same as current. Mitigate by monitoring, enforcement, suspension of licenses, etc.
	Limit purchase amounts to reduce consumption and stop sales to unlicensed outlets (e.g. equivalent of 48 or 72 standard drinks) *#~	Industry creates ID-based system linked to national database. Limit how much can be transported by individuals without licenses.	All traders to use the system to prevent people buying small amounts from multiple outlets.
	Industry to reduce manufacturing to 70% of capacity -- perhaps close some breweries	Reduces alcohol availability and incentive to sell more. Avoids stopping production altogether.	Persuading industry. Monitoring compliance
	No off-sales by on-consumption outlets (or any unlicensed outlet) – reduce availability significantly.	Of 90 000 licensed liquor outlets, 25 000 are off-consumption and 65 000 on consumption.	Economic hardship. Mitigate by supporting esp. licensed small subsistence outlets
Drink driving counter-measures and policing of public and illegal drinking	Reduce BAC level for drivers to 0.02 g AA/100ml blood or less	Fast-track Road Traffic Amendment Bill [1] currently on Parliamentary 2020 agenda.	Same as current, though easier to enforce
	Test blood alcohol after serious motor vehicle collisions	Improve systems and turn-around times.	Requires policing & judicial response
	Action against public drinking illegal drinking at on-consumption outlets, licensed and unlicensed	Accompanied by visible awareness-raising campaign	Requires policing & judicial response
Advertising and packaging	Only permit advertising factual information about product (not lifestyle) & only at point of sale. No specials on bulk purchases.	Include ban on 'responsible drinking' ads because generally done by reinforcing the 'lifestyle' aspects of alcohol consumption. [2]	Resistance from alcohol industry and advertising industry
	Ban sale of large containers which encourage excessive drinking e.g. limit to 500ml beer and cider, 750ml wine and 750ml spirits	SAMRC research shows larger containers linked to higher consumption; stops sharing from same container; increases price so reduces consumption	Resistance from industry and consumers
	Point-of-production to point-of-sale system by industry to track products back to source of supply and stop sales to unlicensed outlets ^	This worked in Russia[3] - action is possible against unlicensed seller and licensed supplier who sold the alcohol to them.	Resistance from industry

* Equivalent of 24 standard drinks (24 x 330ml beers or 4 bottles 750 ml wine or 1 bottle 750ml spirits), all sales registered on a centralised database (eg the way Dischem works).
** Everybody to present ID at point of sale/delivery.
*** Delivery no sooner than 2 hours after order made & do age verification before handing over.
\# Revisit after Covid-19 sorted, but don't return to pre-COVID-19 operating hours, i.e. establish a 'new, safer norm'.
~ Purchases above a certain limit must require production of a liquor license.
^ Important for preventing the sale of alcohol products to unlicensed outlets.

What are some of the consequences of maintaining the status quo likely to be?

If we do not respond by reintroducing a ban or other measures to reduce alcohol sales and consumption, we can expect the rate of trauma cases presenting to remain the same – i.e. to pre-lockdown levels or 80%-90% thereof. In addition, there may be more negative outcomes for these cases because of shortage of staff, beds and equipment arising from the competing needs of COVID-19 patients. Consequently, we might expect to see a higher proportion of fatalities, disabilities and long-term effects not only among trauma cases, but also among patients presenting for other conditions including Covid-19.

[1] http://www.nwpg.gov.za/Community_Safety_and_Transport_Management/new/documents/traffic.pdf

[2] For example: https://twitter.com/blacklabelsa/status/1280062016170921984?s=20

[3] https://apps.who.int/iris/bitstream/handle/10665/328167/9789289054379-eng.pdf?sequence=1&isAllowed=y

Should liquor interventions be implemented at a national, provincial or local government level?

Table 4 demonstrates the heterogeneity of the epidemic within the country and might justify imposing ban/restrictions differentially at provincial level as opposed to one unifying move for the whole country. **On the question of whether a ban on liquor sales should be implemented at a national, provincial or local government level, our preference is for reinstating a ban at a national level due to the logistics of both preventing the distribution of liquor from areas where sales are permitted to those where it is not.** If the decision is to go with a provincial ban, it will be important to ensure that there is sufficient control over the movement of alcohol across provincial borders.

If the decision is taken to focus on strategies other than a national ban, i.e. one or more of those alcohol control measures referred to above, then this should be implemented ideally at a national level, especially those focusing on drink-driving countermeasures and alcohol advertising. Given that retail sales of alcohol is a provincial competency, those measures focusing on availability could, in principle, be implemented at a provincial level, but this is not recommended as the optimum solution.

Table 4. Positive cases per province as of 5th July 2020: NICD website

Province	Total cases for 5 July 2020	Percentage total
Eastern Cape	35 648	18
Free State	2 553	1,3
Gauteng	63 404	32,2
KwaZulu-Natal	15 146	7,7
Limpopo	1706	0,9
Mpumalanga	1955	1,0
North West	6063	3,1
Northern Cape	734	0,4
Western Cape	69 531	35,3
Unknown	0	0,0
Total	**196 750**	**100,0**

Conclusion

The country is experiencing a surge in many of the metropoles. Considering that our health care system is fragile with little reserve it makes sense to protect our resources as much as possible and as early as possible. In addition, we expect the major impact of the ban/restriction to be gradual over several weeks. Therefore, we favour an early implementation of a ban/restriction. It should be noted that there are multiple pressures on the government to relax current restrictions on alcohol and given the above it is clear that these should not be entertained.

It is imperative to maintain absolute transparency and inform the public of rationale behind its decision to re-impose a ban or tighter restrictions. Sharing the model and the rationale behind the model is key to winning the public over. It is also important to be sensitive to the addictive nature of alcohol and provide details on where and how to seek help for dealing with alcohol withdrawal/dependence.

For the future, we strongly recommend that all trauma related to alcohol should be made reportable/notifiable so we can build a sustained bank of information to inform the impact on the health system and economy of the country.

References

1. De Wet, P (25 March 2020). Car crashes, violence down in SA after new alcohol rules, emergency responders say. Business Insider SA. https://www.businessinsider.co.za/car-accidents-decreased-after-bars-were-closed-early-before-the-national-lockdown-2020-3 (accessed 26/3/2020).
2. Matzopoulos, R.G.; Prinsloo, M.; Butchart, A.; Peden, M.M.; Lombard, C.J. Estimating the South African trauma caseload (2006). Int J Inj Contr Saf Promot 13, 49-51. DOI:10.1080/15660970500036382
3. Parry, C.D.H., Nicol, A.J., Navsaria, P., & Matzopoulos, R. (under review). Lifting the ban on alcohol sales during the Covid-19 lockdown on admissions to trauma units in South Africa: A modelling study
4. Statistics South Africa. (2019). Mid-year population estimates. Pretoria: Author.
5. Statistics South Africa. (1999). Mid-year population estimates. Pretoria: Author.
6. Western Cape Department of Health. Sentinel Trauma Report (January to June 2020). (2020). Cape Town: Western Cape Provincial Government.

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REPUBLIC OF SOUTH AFRICA

FORM A
REQUEST FOR ACCESS TO RECORD OF PUBLIC BODY
(Section 18(1) of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000))
[Regulation 6]

FOR DEPARTMENTAL USE

Reference number: .....

Request received by ..... (state rank, name and surname of information officer/deputy information officer) on ..... (date) at ..... (place).

Request fee (if any): R .....

Deposit (if any): R .....

Access fee: R .....

.....
SIGNATURE OF INFORMATION OFFICER/DEPUTY INFORMATION OFFICER

A. Particulars of public body

The Information Officer/Deputy Information Officer

Department of Cooperative Governance and Traditional Affairs

Director-General - Mr. DMG Mashitisho,

Sent by email to: DanM@cogta.gov.za (Copy to all Deputy Information Officers by email)

B. Particulars of person requesting access to the record

(a) The particulars of the person who requests access to the record must be given below.
(b) The address and/or fax number in the Republic to which the information is to be sent, must be given.
(c) Proof of the capacity in which the request is made, if applicable, must be attached.

Full names and surname: GLYNNIS BREYTENBACH

Identity number:

6	0	0	8	0	9	0	0	7	2	0	8	0

Postal address: .....

Telephone number: (+27) 763067850 Fax number: (.....) .....

E-mail address: glynis.breytenbach@gmail.com (Please CC: hvrprok@gmail.com)

Capacity in which request is made, when made on behalf of another person:

C. Particulars of person on whose behalf request is made

This section must be completed ONLY if a request for information is made on behalf of another person.

Full names and surname: .....

Identity number:

D. Particulars of record

(a) Provide full particulars of the record to which access is requested, including the reference number if that is known to you, to enable the record to be located.
(b) If the provided space is inadequate, please continue on a separate folio and attach it to this form. The requester must sign all the additional folios.

1. Description of record or relevant part of the record:

SEE ANNEXURE "A" ATTACHED

.....

.....

2. Reference number, if available: .....

3. Any further particulars of record:

SEE ANNEXURE "A" ATTACHED

.....

.....

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.....

E. Fees

(a) A request for access to a record, other than a record containing personal information about yourself, will be processed only after a request fee has been paid.
(b) You will be notified of the amount required to be paid as the request fee.
(c) The **fee payable for access** to a record depends on the form in which access is required and the reasonable time required to search for and prepare a record.
(d) If you qualify for exemption of the payment of any fee, please state the reason for exemption.

Reason for exemption from payment of fees:

MEMBER OF PARLIAMENT REQUIRING INFORMATION FOR OVERSIGHT PURPOSES IN THE NATIONAL INTEREST

.....

.....

.....

F. Form of access to record

If you are prevented by a disability to read, view or listen to the record in the form of access provided for in 1 to 4 below, state your disability and indicate in which form the record is required.

Disability: N/A

Form in which record is required:

Mark the appropriate box with an **X**.

WRITTEN OR PRINTED

NOTES:
(a) Compliance with your request for access in the specified form may depend on the form in which the record is available.
(b) Access in the form requested may be refused in certain circumstances. In such a case you will be informed if access will be granted in another form.
(c) The fee payable for access to the record, if any, will be determined partly by the form in which access is requested.

1. If the record is in written or printed form:					
X	copy of record*		inspection of record		
2. If record consists of visual images - (this includes photographs, slides, video recordings, computer-generated images, sketches, etc.):					
	view the images	X	copy of the images*		transcription of the images*

3. If record consists of recorded words or information which can be reproduced in sound:						
X	listen to the soundtrack (audio cassette)	X	transcription of soundtrack* (written or printed document)			
4. If record is held on computer or in an electronic or machine-readable form:						
	printed copy of record*		printed copy of information derived from the record*	X	copy in computer readable form* (stiffy or compact disc)	

*If you requested a copy or transcription of a record (above), do you wish the copy or transcription to be posted to you? Postage is payable.	YES	NO X
Note that if the record is not available in the language you prefer, access may be granted in the language in which the record is available.		
In which language would you prefer the record? ENGLISH		

G. Notice of decision regarding request for access

You will be notified in writing whether your request has been approved / denied. If you wish to be informed in another manner, please specify the manner and provide the necessary particulars to enable compliance with your request.

How would you prefer to be informed of the decision regarding your request for access to the record?

EMAIL TO glynis.breytenbach@gmail.com (CC TO hvrprok@gmail.com)

Signed at CAPE TOWN this day 8th of MAY year 2020

SIGNATURE OF REQUESTER / PERSON ON WHOSE BEHALF REQUEST IS MADE

GLYNNIS BREYTENBACH MP

ANNEXURE A

1. A copy of the designation in terms of which the Minister of Cooperative Governance and Traditional Affairs("the Minister") was appointed in terms of Section 3 of the Disaster Management Act, Act 57 of 2002 ("the Act") to administer the Disaster Management Act, 57 of 2002.

2. Copies of the decisions and/or reports, together with a list of all the Constitutional and/or statutory provisions in terms of which the COVID19 National Command Council was constituted and terms of which it takes decisions and/or make recommendations to the Minister as designated in terms of section 3 of the Disaster Management Act, 57 of 2002.

3. Copies of all minutes and resolutions and/or recommendations made by the COVID-19 National Command Council ("the NATIONAL COMMAND COUNCIL").

4. The names and positions/designations of all members of the COVID-19 NATIONAL COMMAND COUNCIL and/or all correspondence pertaining to their respective appointments.

5. A copy of the designation in terms of which the Head of the National Disaster Management Centre, Dr. Mmaphaka Tau ("Dr.Tau) was appointed in terms of Section 10 of the Disaster Management Act, Act 57 of 2005 (or "the Act") to administer the Disaster Management Act, 57 of 2002.

6. Records of any on-site inspections conducted, copies of all presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models and/or expert reports and/or any other documentation upon which a decision was made by Dr.Tau to classify the COVID-19 pandemic as a national disaster, as contained in *Government Gazette No 43096, dated 15 March 2020, Notice 312 of 2020* in terms of section 23(2) of the Act.

7. Copies of documentation depicting the disaster risk analysis and/or assessment process that was followed prior to making the decision in terms of Section 23(2) of the Act.

8. Copies of all Minutes and/or any other records and attendance registers in respect of any or all meeting(s) held with interested and/or affected parties, including vulnerable communities and households (including physically isolated communities and female-headed households) as contemplated by the community-based disaster risk assessment.

9. Copies of correspondence and/or documents and/or reports containing the decision to classify the COVID-19 pandemic as a national disaster, including a copy of the register containing the prescribed particulars concerning the COVID-19 pandemic in terms of Section 23(1)(c) of the Act.

10. A copy of and/or copies of Service Level Agreement(s) concluded between the National Disaster Management Centre and (an) independent assessor(s), as contemplated in terms of section 23(2)(b) of the Act, if any.

11. In the event that (an) assessor(s) was / were enlisted in terms of Section 23(2)(b) of the Act, a copy of and/or copies of the Curriculum Vitae of the assessor(s) so enlisted.

12. A copy of Dr. Tau's Curriculum Vitae prior to his appointment Head, alternatively Acting Head, of the National Disaster Management Centre.

13. Copies of any requests directed to any organ of state and/or person in possession of information to provide such information as contemplated in Section 18 of the Act and copies of any communication directed to the Minister for the failure to comply with the request in terms of Section 18(1) of the Act.

14. Copies of all the records of advice and guidance given by the National Disaster Management Centre in terms of Section 22 of the Act.

15. Copies of all existing mutual assistance agreements and Memorandums of Understanding concluded between all national departments, provinces, municipalities, the private sector, non-governmental organisations, traditional leaders, technical experts and volunteers in disaster management as contemplated in Section 7(2)(f)(I) of the Act read together with a 1.4.3 contained in the National Disaster Management Framework published under in *Government Gazette No 27534, dated 29 April 2005, General Notice 654 of 2005*

16. Copies of any/or all minutes of meetings and/consultations held between the National Disaster Management Centre and all spheres of Government immediately prior to making a decision to classify the COVID-19 pandemic as a national disaster.

17. Copies of all reports submitted by all organs of state as contemplated in Section 24(4) – Section 24(8) of the Act and as required in *Government Gazette No 43096, dated 15 March 2020, Notice 312 of 2020*

18. Copies of all presentations, assessment reports or any other reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models and/or expert reports and/or any other documentation which the Minister was furnished with, considered and not adopted or accepted by, her and upon which a decision was made by the Minister to declare a national state of disaster, as contained in Government Gazette No.43096 dated 15 March 2020, Notice 313 of 2020.

19. Copies of the resolution to declare a national state of disaster following a special Cabinet meeting held on 15 March 2020.18.

20. Copies of all presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation which was furnished to the Minister, considered and not adopted or accepted by, her and upon which the regulations in terms of section 27(2) read

together with section 27(3) of the in Government Gazette No. 43107 dated 18 March 2020, Notice 318 of 2020 were premised.

21. Copies of the minutes of meetings and or the record of discussions in respect of all meetings held as well as copies of the attendance registers depicting the relevant Cabinet members with whom the Minister consulted with immediately prior to publishing the Regulations contained in Government Gazette No. 43107 dated 18 March 2020, Notice 318 of 2020.

22. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations contained in Government Gazette No. 43107 dated 18 March 2020, Notice 318 of 2020) were premised by other members of the National Executive of Government.

23. Copies of the minutes of meetings held in respect of and copies of the signed resolution taken and or the record of decision-making to establish the "Command Council" as defined in the Government Gazette No. 43147 dated 25 March 2020, Notice 399 of 2020 as well as documentation reflecting the details of the members of the "Command Council" as defined.

24. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and upon which a decision was made by the Minister to publish amended regulations in terms of section 27(2) read together with section 27(3) of the Act by publishing Regulations under Government Notice no. 419 of Government Gazette No 43168 dated 26 March 2020 were premised.

25. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other

documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations under Government Notice no. 419 of Government Gazette No 43168 dated 26 March 2020) were premised by other members of the National Executive of Government.

26. Copies of the minutes of meetings held and or copies of the record of discussion as well as copies of the attendance registers depicting the relevant Cabinet members with whom the Minister consulted with immediately prior to publishing the Regulations contained in Government Gazette No. 43618 dated 26 March 2020, Notice 419 of 2020.

27. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, an upon which a decision was made by the Minister to publish amended regulations in terms of section 27(2) read together with section 27(3) of the Act by publishing Regulations under Government Notice no. 432 of Government Gazette No 43184 dated 30 March 2020 were premised.

28. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which a decision was made by the Minister to amend the regulations in terms of section 27(2) read together with section 27(3) of the Act by publishing Regulations in Government Notice no. 446 of Government Gazette No 43199 dated 2 April 2020 were premised.

29. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations under Government Notice no. 432 of Government Gazette No 43184

dated 30 March 2020 were premised by other members of the National Executive of Government.

30. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations in Government Notice no. 446 of Government Gazette No 43199 dated 2 April 2020) were premised by other members of the National Executive of Government.

31. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which amendment/s of the regulations in terms of section 27(2) read together with section 27(3) of the Act in Government Notice no. 465 of Government Gazette No 43232 dated 16 April 2020 were premised.

32. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations in terms of section 27(2) read together with section 27(3) of the Act in Government Notice no. 465 of Government Gazette No 43232 dated 16 April 2020) were premised by other members of the National Executive of Government.

33. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which a decision was made by the Minister to amend the regulations in terms of section 27(2) read together with section 27(3) of the Act by publishing Regulations

Government Notice no. 471 of Government Gazette No 43240 dated 20 April 2020 were premised.

34. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations Government Notice no. 471 of Government Gazette No 43240 dated 20 April 2020) were premised by other members of the National Executive of Government.

35. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which a decision was made by the Minister to amend the regulations in terms of section 27(2) read together with section 27(3) of the Act by publishing Regulations Government Notice no. 398 of Government Gazette No 43148 dated 20 April 2020 were premised.

36. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations Government Notice no. 398 of Government Gazette No 43148 dated 20 April 2020) were premised by other members of the National Executive of Government.

37. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and upon which the Alert Level 4 Lockdown

regulations in terms of section 27(2) read together with section 27(3) of the Disaster Management Act, 57 of 2002 in Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 were premised.

38. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives (issued after the publishing of the Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020) were premised by other members of the National Executive of Government

39. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation upon which the classification of the National Disaster in terms of section 23 of the Disaster Management Act, 57 of 2002, when it was pronounced was premised, together with the scales, models or other weighting method that was used to determine the level or scale of the disaster that culminated into the declaration of National Disaster on 15 March 2020.

40. Details of all or any other legislation that was considered to manage and curb the spread and/or effects of the COVID19 virus in accordance with section 27(3) of the Disaster Management Act, 57 of 2002.

41. A list of Constitutional or other statutory provisions of which the operation was limited, suspended or that have been superseded by the regulations issued in terms of Section 27(2) read together with section 27(3) of the Disaster Management Act, 57 of 2002 and copies of all or any presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation upon which the necessary extent thereof has been determined.

42. A full list of dates and times of the meetings of the COVID19 National Command Council since its establishment.

43. The minutes and or record of decision-making of the COVID19 National Command Council in respect of every meeting it has held since its establishment.

44. Full details as to all of the advisory memoranda and or advice in any other format than memoranda which the COVID19 National Command Council has given to the national executive.

45. All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which any and all of the decisions and or advice given to the national executive have been based by the COVID19 National Command Council.

46. Full details as to the record of decision-making by the COVID19 National Command Council in respect of each and every economic activity it advised the National Executive and or the Minister not to allow in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why such economic activities were advised to be prohibited.

47. Full details as to the record of decision-making by the Minister in respect of each and every economic activity she resolved not to allow in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why such economic activities were prohibited, irrespective of whether she resolved on the matter unilaterally or as part of any collective.

48. Full details of the record of decision-making by the Minister in respect of the limitations placed on the movement of people in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why these limitations were imposed, irrespective of whether she resolved on the matter unilaterally or as part of any collective.

49. Full details of the record of decision-making by the Minister in respect of the limitations placed on trade and retail as reflected in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why these limitations were imposed, irrespective of whether she resolved on the matter unilaterally or as part of any collective.

50. Full details of the record of decision-making by the Minister in respect of the limitations placed on the service sector of the economy as reflected in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why these limitations were imposed, irrespective of whether she resolved on the matter unilaterally or as part of any collective.

DATES OF NCCC MEETINGS

MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV
19	2	6	2	1	4	1		
22	8	10	9	9	11	8		
24	13	13	16	14	25	14		
29	16	18	25	21		15		
	19	20		28		22		
	23	26				29		
	24							
	29							
	30							

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Enquiries: Prof S Abdool Karim
E-mail: salim.abdoolkarim@caprisa.org

INTERNAL MEMO

Date:	22 July 2020		
To:	**Minister ZL Mkhize**	From:	**Ministerial Advisory Committee (MAC) on COVID-19**

ADVISORY ON THE NCCC QUESTIONS ON ACTIONS TO CURB THE SURGE

Problem Statement

- *Question 1: What have the effects of the lockdown initially and its releasing now been on the epidemic trajectory?*
- *Question 2: Based on the attached paper, is a cyclic lockdown approach suitable for SA?*
- *Question 3: What metric and threshold of this metric would be appropriate for potentially re-introducing a local, regional or national level 5 restrictions?*
- *Question 4: Should an alcohol restriction be considered*
- *Question 5: Before we consider changing alert levels, are we doing what we can with prevention tools, or is there anything more that could be done.*

Evidence review

The evidence considered is provided in the 5 attachments:
Attachment 1 – Criteria and thresholds for restrictions
Attachment 2 – Impact of the lockdown
Attachment 3 – Should cyclic lockdowns be considered
Attachment 4 – Considerations on alcohol restrictions
Attachment 5 – Action steps on prevention priorities

Recommendations

The 5 attachments list the recommendations. A summary of the recommendations is provided in the attached slide presentation for the NCCC (Attachment 6) and captured below:

Definition of hotspots: While cases, hospitalisations and deaths say different things as indicators, admissions (bed occupancy) were considered most relevant and aligned well with the flattening the curve goal

Use of a lockdown and/or cyclic lockdowns: A level 4 or Level 5 lockdown, including intermittent lockdowns, is not a sustainable option to address the current surge of Covid-19 cases in Gauteng (or elsewhere), and at best would only delay the surge of cases.

Alcohol: While some members did not think the MAC was the appropriate body to advise on alcohol and some had reservations about restricting alcohol, the technical working group on alcohol recommended either:

Option 1: Temporary alcohol ban – An alcohol ban over the next 8-weeks, models estimate could reduce the alcohol admissions of 189,677 days in general wards and 17,714 ICU-bed days by 20%-30%

Option 2: Partial alcohol restrictions – such as a ban on the sale of large containers of alcohol, setting purchase limits, reducing drunk driving alcohol limit, etc.

Prevention priorities for implementation (from attachment 5):

1. Active education on importance of social distancing, hand hygiene and wearing of face masks
2. Promote physical distancing in all public spaces. In closed areas such as public transport or an office where physical distancing is not feasible, ensure adequate ventilation (including leaving windows open and not using recirculation ventilators). The role of air conditioners is under investigation but limiting their use seems prudent at this stage.
3. Regulate the compulsory wearing of masks in public spaces, especially where physical distancing is difficult to maintain (e.g. Shopping centers)
4. Prohibiting conditions lending itself to heightened rate and risk of transmission; including rolling back:
    a. The lifting of restrictions on places of worship
    b. Opening of cinemas and casinos,
    c. Reducing occupancy allowed in taxis (change back to 50% occupancy) and other public transport;
    d. Opening of restaurant dining in closed spaces, until the wave of the outbreak has subsided.
5. Re-instatement of banning of liquor sales, both because drinking in groups can lend itself to increase rates of transmission; as well as the impact that alcohol abuse is having on demands on health care facilities.
6. Re-instatement of a curfew to reduce road accidents and after hour's trauma to reduce demands on emergency rooms and trauma-related bed.
7. Enhance effective policing of settings that lend itself to heightened rates of transmission, including in shopping places, taxi ranks and religious gatherings.

Kind regards,



PROFESSOR SALIM S. ABDOOL KARIM
OVERARCHING CHAIRPERSON: MINISTERIAL ADVISORY COMMITTEE ON COVID-19
DATE: 22 July 2020

CC:

» **Dr ZL Mkhize (Minister of Health, MP)**
» **Dr T Pillay (Acting Director-General)**
» **Dr S Zungu (Project Lead: Sectoral Response to Covid-19)**
» **Incident Management Team**

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Enquiries: Prof S Abdool Karim
E-mail: salim.abdoolkarim@caprisa.org

INTERNAL MEMO

Date:	03 July 2020		
To:	**Dr ZL Mkhize** **Minister of Health**	From:	**Ministerial Advisory Committee (MAC) on COVID-19**

ADVISORY ON TAXI OCCUPANCY LEVELS TO MITIGATE COVID-19 RISK

Request for Advisory sent to MAC/Problem/Concern

Does an increase in taxi occupancy from 70% to 100% pose a public health threat of increased SARS-CoV-2 transmission? If so, are there mitigation measures that can ameliorate the increased risk of viral transmission?

MAC review

The coronavirus spreads from person to person mainly through respiratory droplets and contact when people touch contaminated surfaces (Chu, 2020). Direct and prolonged (>15 minutes) close contact in poorly ventilated areas are considered to carry the highest risk, through an infected individual's (symptomatic or asymptomatic) droplets from the respiratory tract reaching an uninfected person's mouth, nose or eyes.

The Coronavirus is spread through 3 modes of transmission:

1. Direct inoculation with infected droplets.
2. Indirectly through contact with contaminated surfaces, and subsequent self-inoculation.
3. Airborne transmission through micro-droplets (<5µm) that remain airborne for 10-15 minutes, especially in poorly ventilated areas. The contribution of airborne transmission remains unresolved.

There is evidence that for other respiratory disease with similar modes of transmission (influenza A (H1N1)), use of public transport (such as taxis) is associated with increased risk of illness (Zhen 2020). Since public transport comprises a risky situation due to lack of safe distance between passengers, drivers and conductors, and a high likelihood of contaminated surfaces from infected passengers, drivers and conductors; special precautions are warranted. Two of the most important reasons for the high risk in public transport are:

1. Close contact between people and inability to maintain 1.5 meter distance between people due to seating. Prolonged contact of >15 minutes for most journeys.

2. Gathering of large groups of individuals (>10 people) leading to increased possibility of one of the individuals in the group being infected and the risk of that infected individual transmitting the virus onward to large numbers of people

Most notably, drivers and conductors carry a particularly high risk of Coronavirus infection as they have the longest exposure to potentially infectious individuals each day without the benefit of social distancing. The risk of transmission between passengers, from passengers to the driver/conductor and from the driver/conductor to passengers due to the 2 points above can be reduced by reducing taxi occupancy allowing spacing between occupied seats and reducing the numbers of individuals in a confined space for a period of time. Also, there should not be anyone allowed in the seat next to the driver/conductor, and ideally a barrier between the driver/conductor and the back of the taxi. Reducing the risk of passengers and drivers/conductors acquiring coronavirus infection is important because there several million taxi passengers and tens of thousands of drivers/conductors and their high infection rates could lead to substantial community transmission.

Under level 4 restrictions, taxis were only allowed to load passengers to a maximum of 50% occupancy, until the Minister of Transport increased the threshold to 70%. A threshold of 70% occupancy translates to a maximum of 10 people in a taxi that would normally carry 15 passengers.

The approach to this problem in buses and subway trains in the US is captured in the US CDC guidelines to maintain safe social distancing among bus and subway riders recommend the following:

1. Lower the maximum number of people allowed aboard.
2. Restrict every second row of seats to keep people further apart.
3. Provide additional services to reduce the number of riders per trip.
4. Install marking and physical guides to ensure riders can stay six feet apart.
5. Daily health checks for bus drivers and transit workers.
6. Eliminate touchpoints like fare boxes, doors and trash cans.

The proposal to increase taxi occupancy to 100% presents a high risk of accelerating coronavirus transmission, especially for drivers and conductors who will be in close contact with potentially infectious individuals for many hours each day and infected drivers/conductors pose a risk of transmission to their close contacts, including their families and to passengers. It also presents a risk for infected passengers to transmit the virus to other passengers.

With regard to steps to be taken to mitigate coronavirus risk, the use of masks could reduce the risk of spread by droplets, hand sanitising can reduce transmission from contaminated surfaces while open windows are critically important to reduce droplet and airborne spread. These measures can be used to minimise the increased transmission risk from close contact and an increased risk of having an infected individual when there are larger numbers of passengers.

References

1. Chu DK, Duda S, Solo K, YAacoub S, Schuneman H, SURGE. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. Lancet 2020.

2. Zhen J, Chan C, Schoonees A, Apatu E, Thabane L, Young T. Transmission of respiratory viruses when using public ground transport: a rapid review to inform public health recommendations during the COVID-19 pandemic. SAMJ. 2020.

Recommendations:

1. Taxi occupancy should not be increased above the current 70% level.

2. Consideration should be given to reducing occupancy to 50% in areas where the numbers of active Covid-19 cases are high and rising.

3. Since drivers and conductors are at highest risk due to high-risk of exposure and inadequate social distancing in the vehicle for prolonged periods, the following risk mitigation measures are recommended for drivers:
    a. Drivers and conductors should complete a daily symptom check before being allowed to drive a taxi.
    b. Drivers and conductors should wear a mask.
    c. Drivers and conductors should practice physical distancing when out of their taxis, especially at taxi ranks.
    d. The drivers, conductors and passengers windows should be opened sufficiently to allow substantial airflow across the front seats of the taxi.
    e. The taxi interior and touch surfaces, such as door handles should be wiped down at least once each day.
    f. Drivers should ensure that their taxi ranks have floor markings and physical guides installed to keep awaiting passengers at least 1m apart.
    g. The seat next to the driver should be left open, unless utilised by the taxi conductor.

4. Since passengers are exposed to risk when riding in a taxi, the following mitigation measures are recommended for passengers:
    a. Passengers should observe physical distancing rules while waiting for taxis.
    b. Each passenger should wear a mask.
    c. Each passenger should hand sanitise on entry into the taxi.
    d. Passengers should avoid touching taxi surfaces where possible.
    e. It is recommended that at least 2 passenger windows on each side of the taxi are opened to allow sufficient airflow in the taxi cabin.

Thank you for consideration of this request.

Kind regards,



PROFESSOR SALIM S. ABDOOL KARIM
OVERARCHING CHAIRPERSON: MINISTERIAL ADVISORY COMMITTEE ON COVID-19
DATE: 03 July 2020

CC:
- **Dr S Buthelezi (Director-General: Health)**
- **Dr T Pillay (Deputy Director-General: National Health Insurance)**
- **Dr S Zungu (Project Lead: Sectoral Response to Covid-19)**
- **Incident Management Team**

THE PRESIDENCY
REPUBLIC OF SOUTH AFRICA

OFFICE OF THE CHIEF OPERATIONS OFFICER

Private Bag X1000, PRETORIA, 0001

Enq: Mr Justice Hlungwani
Tel: 012 300 5376
Email: Justiceh@presidency.gov.za

Our Ref: PAIA/12/2020/21

Adv. Glynnis Breytenbach, MP
Po Box 15
Cape Town
8000

Per email: glynis.breytenbach@gmail.com / glynnis.breytechbach@gmail.com
hvrprok@gmail.com

Dear Adv. Breytenbach

REQUEST FOR INFORMATION - ADV. GLYNNIS BREYTENBACH, MP

1. We refer to your request for access to information in terms of the Promotion of Access to Information Act 2 of 2000 ("PAIA"), dated 8 May 2020.

2. We confirm that the Presidency responded to that request on 14 September 2020 by providing you with some of the documents that you requested and declining to provide others. In that response, the Presidency also requested the following:

    a. We identified that some items were too broad and invited you to please assist us by narrowing down the documents that you request so that we are able to better facilitate the request; and

    b. For those items containing documents marked "classified secret/privileged", we requested an opportunity until 8 October 2020 for Cabinet to consider whether it can provide them to you.

3. After consideration of the documents that are marked "classified secret/privileged", it has been established that the following items are Cabinet records and access to them cannot be sought in terms of PAIA. This is so because in terms of section 12(a), PAIA does not apply to records of Cabinet and its committees.

    a. Item 3: Copies of all minutes and resolutions and/or recommendations made by the COVID- 19 National Command Council.

    b. Item 19: Copies of the resolution to declare a national state of disaster following a special Cabinet meeting held on 15 March 2020.

c. Item 21: Copies of the minutes of meetings and or the record of discussions in respect of all meetings held as well as copies of the attendance registers depicting the relevant Cabinet members with whom the Minister consulted with immediately prior to publishing the Regulations contained in Government Gazette No. 43107 dated 18 March 2020, Notice 318 of 2020.

d. Item 23: Copies of the minutes of meetings held in respect of and copies of the signed resolution taken and or the record of decision-making to establish the "Command Council" as defined in the Government Gazette No. 43147 dated 25 March 2020, Notice 399 of 2020 as well as documentation reflecting the details of the members of the "Command Council" as defined.

e. Item 43: The minutes and or record of decision-making of the COVID19 National Command Council in respect of every meeting it has held since its establishment.

f. Item 44: Full details as to all of the advisory memoranda and or advice in any other format than memoranda which the COVID19 National Command Council has given to the national executive.

g. Item 45: All presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which any and all of the decisions and or advice given to the national executive have been based by the COVID19 National Command Council.

h. Item 46: Full details as to the record of decision-making by the COVID19 National Command Council in respect of each and every economic activity it advised the National Executive and or the Minister not to allow in Regulations Government Notice no. 480 of Government Gazette No 43258 dated 29 April 2020 and or any directives issued by any Minister subsequent to the aforesaid regulations, including the full and detailed reasons why such economic activities were advised to be prohibited.

4. The Presidency is therefore unable to provide you with access to these documents.

5. The following documents are provided with this letter:

a. The list of dates and times of the meetings of the National Coronavirus Command Council on COVID-19 since its establishment, which is information that is in the public domain as such dates and times were generally announced around the relevant times.
b. Ministerial Advisory Committee on COVID-19 ("MAC") document: Fitness Industry Reopening Framework;
c. MAC Presentation to the National Coronavirus Command Council 9 July 2020;
d. MAC document: Considerations on alcohol restrictions;
e. MAC Advisory on the NCCC questions on actions to curb the surge; and
f. MAC Advisory on taxi occupancy levels to mitigate covid-19 risk.

6. In relation to Items 22, 25, 29, 30, 32, 34, 36 and 38, wherein you requested all presentations, reports, best practices, recommendations, statistics, scientific/medical evidence, treaties, models or expert reports or any other documentation furnished to, considered and not adopted or accepted by, and upon which the exercise of the authority to issue directives were premised by other members of the National Executive of Government, the Presidency sought to obtain this information from the Ministers that issued directions.

However, the request is rather broad and the Presidency has not been able to garner the resources to obtain these documents from the various Ministers. Instead of declining the request on any basis permissible under PAIA (and making clear that this ought not to be treated as a deemed refusal), the Presidency invites you to seek this information directly from the respective Ministries. This will facilitate a proper response and make the request less cumbersome when directed to the Ministers themselves. A list of Ministers that issued directions can be found at:

[https://www.gov.za/covid-19/resources/regulations-and-guidelines-coronavirus-covid-19?gclid=CjwKCAjwzvX7BRAeEiwAsXExo4l64SfyS9qGSz5vQX4JaHELUPXkd1pcm3k13H6n6aUKnBHWuNOSGhoCv_oQAvD_BwE] (last accessed on 7 October 2020 at 20:15)

7. The Department of Cooperative Governance and Traditional Affairs ("COGTA") is still considering the request in items 18, 24, 26, 27, 28, 33, 35, 40, 47, 48, 49, and 50. We appreciate that this ought to have been done by today, however our colleagues at COGTA, who are better placed to consider those requests because of their nature, have not been able to finalise their consideration.

Yours sincerely

Mr. Thulani Mdakane
Acting Deputy Information Officer
Date: 08/10/2020

THE PRESIDENCY
REPUBLIC OF SOUTH AFRICA

OFFICE OF THE CHIEF OPERATIONS OFFICER

Private Bag X1000, PRETORIA, 0001

Enq: Mr Justice Hlungwani
Tel: 012 300 5376
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Our Ref: PAIA/12/2020/21

Adv. Glynnis Breytenbach, MP
Po Box 15
Cape Town
8000

Per email: glynis.breytenbach@gmail.com / glynnis.breytechbach@gmail.com
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Yours sincerely

Mr. Thulani Mdakane
Acting Deputy Information Officer
Date: 08/10/2020

DEPARTMENT OF CO-OPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

NO. R. 432 **30 MARCH 2020**

DISASTER MANAGEMENT ACT, 2002

DIRECTIONS ISSUED IN TERMS OF SECTION 27(2) OF THE DISASTER MANAGEMENT ACT, 2002 (ACT NO. 57 OF 2002)

I, Dr Nkosazana Dlamini Zuma, the Minister of Cooperative Governance and Traditional Affairs, hereby, in terms of section 27(2) of the Disaster Management Act, 2002 (Act No. 57 of 2002), issue the directions in the schedule hereto, to address, prevent and combat the spread of COVID-19 in South Africa.

NC Zuma

DR NKOSAZANA DLAMINI ZUMA, MP
MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

30.03.2020

This gazette is also available free online at www.gpwonline.co.za

SCHEDULE

Definitions

1. In these directions, "Directions" means the directions published by Government Notice No. 399 of 25 March 2020.

Amendment of the Directions

2. **Direction 6.7 of the Directions is hereby amended by the substitution with the following Direction:**

"6.7. Municipal operations and governance

6.7.1 Municipalities are required to perform various legislated functions, including consultation processes, the passing of budgets and the adoption of integrated development plans (IDPs).

6.7.2 Only meetings of the Metropolitan and District Command Centres may be undertaken during the initial 21 Day Lockdown period, or any other extended period of Lockdown that may be declared.

6.7.3 Municipalities are directed to:

(a) Suspend all council meetings during the initial 21 Day Lockdown period, or any other extended period of Lockdown that may be declared.
(b) Not convene any meetings, including the IDP community and consultation processes and the consideration and passing of budgets, during the initial 21 Day Lockdown period, or any other extended period of Lockdown that may be declared.
(c) Ensure that after the Lockdown period or any other extended period of Lockdown, but still during the national state of disaster, meetings requiring more than 100 persons to be present, make appropriate alternative arrangements for meetings to proceed. These arrangements may include the viewing of proceedings from different venues, and then casting their votes in the council chambers in groups, which do not exceed the 100-person limit at any given time, or counting the

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votes made in the different venues and then such votes added to inform decision-making.

(d) Undertake emergency procurement within the framework of the Disaster Management Act, 2002 and the transversal contracts issued by the National Treasury, that have been finalised by the Municipal Infrastructure Support Agent prior to the pandemic. (please just make sure that these are indeed transversal contracts) see PFMA and MFMA.

(e) Adhere to all applicable National Treasury Regulations and MFMA Circular 100, *Emergency Procurement in Response to COVID-19 Pandemic,* that were issued by the National Treasury in terms of the *Municipal Finance Management Act,* 2003 (Act No. 56 of 2003).

(f) Ensure that during the initial 21 Day Lockdown period, or any other extended period of Lockdown that may be declared, notwithstanding any requirements in terms of any systems of delegation of municipalities, decision-making that would have required the approval of councils, council committees, mayoral or executive committees, will be made by the Municipal Manager on written recommendation of the Chief Financial Officer and with approval or concurrence of the mayor or executive mayor.

(g) Ascertain that decisions taken in respect of paragraph (f) above must be of an emergency nature and which may not be able to be deferred to after the Lockdown, are reported and ratified in the first meeting of the relevant structure as per the systems of delegation of the municipality.

(h) Report all procurement undertaken during the period of the state of disaster to the first council meeting after the lapsing or the termination of the state of disaster.

6.7.4 Municipal entities are directed to:

(a) Ensure that during the initial 21 Day Lockdown period, or any other extended period of Lockdown that may be declared, notwithstanding any requirements in terms of any systems of delegation of municipalities, decision-making that

would have required the approval of councils, council committees, mayoral or executive committees, will be made by the Accounting Officer of the Entity on written recommendation of the Chief Financial Officer and with approval or concurrence of the Chairperson of the Board of the Entity.

(b) Ascertain that decisions taken in respect of paragraph (a) above must be of an emergency nature and which may not be able to be deferred to after the Lockdown, are reported and ratified in the first meeting of the relevant structure as per the systems of delegation of the municipality.

MINISTRY
COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS
REPUBLIC OF SOUTH AFRICA

Private Bag X804, Pretoria, 0001 Tel: (012) 334 0600, Fax: (012) 334 0603
Cnr Hamilton and Proes Street, Arcadia, Pretoria

CIRCULAR NO. 10 OF 2020

FROM: **DR NKOSAZANA DLAMINI ZUMA, MP**
MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

TO: **ALL PREMIERS OF THE PROVINCES**

ALL MECs RESPONSIBLE FOR LOCAL GOVERNMENT IN THE PROVINCES

PRESIDENT OF SOUTH AFRICAN LOCAL GOVERNMENT ASSOCIATION

ALL EXECUTIVE MAYORS / MAYORS

TERMS OF REFERENCE: PROVINCIAL AND MUNICIPAL CORONAVIRUS COMMAND COUNCILS AND PROVINCIAL AND MUNICIPAL CORONAVIRUS COMMAND CENTRES

1. On 25 March 2020, Directions in terms of Section 27(2) of the Disaster Management Act, 2002 (Act No. 57 of 2002) were issued in Government Notice No. 399 (hereafter referred to as the "Directions").

2. The Directions provide that for the duration of the state of disaster, all Premiers, the MECs responsible for local government, the President of SALGA, all Executive Mayors/Mayors, and Institutions of Traditional Affairs shall take all reasonable measures to facilitate and implement the measures contained in the Directions.

3. Paragraph 6.8 of the Directions provide for institutional arrangements and development of COVID-19 response plans. In this regard, provinces and municipalities are directed to, amongst other matters, immediately establish the provincial and district coronavirus command councils, respectively.

4. To guide provinces and municipalities with the establishment of the coronavirus command centres; their functions; and reporting, the attached Terms of Reference has been developed.

5. Further enquiries relating to this matter may be obtained from Dr Mmaphaka Tau: Deputy Director General (Head) of National Disaster Management Centre, by e-mail at: MmaphakaT@ndmc.gov.za, or by mobile phone at: 082 052 9311.

With kind regards,

NC Zuma

DR NKOSAZANA DLAMINI ZUMA, MP
MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

DATE: 04. 04. 2020



TERMS OF REFERENCE

OF THE

PROVINCIAL AND DISTRICT CORONAVIRUS COMMAND CENTRES

TERMS OF REFERENCE FOR THE CORONAVIRUS COMMAND CENTRES AT PROVINCIAL AND DISTRICT LEVEL

1. INTRODUCTION

In consideration of the magnitude and severity of the COVID -19 outbreak which has been declared a global pandemic by the World Health Organisation (WHO), Cabinet in its special Cabinet meeting held on 15 March 2020 resolved to declare a National State of Disaster. In this regard, the Minister of Cooperative Governance and Traditional Affairs (COGTA) issued a Gazette declaring a State of Disaster, in terms of Section 27 of the Disaster Management Act, 2002.

Furthermore, the President of the Republic addressed the nation and announced extra ordinary measures to be implemented to mitigate and combat the spread of Covid-19. To ensure proper monitoring, reporting and implementation of the regulations, directions and guidelines by all relevant sectors, the President established a National Coronavirus Command Council that meets 3 times a week to coordinate responses to the pandemic.

Subsequently, the Minister of COGTA issued Directions and Regulations (Gazettes No 43147 and No.43148, respectively) on 25 March 2020. The directions issued stipulates that for the duration of the state of disaster for COVID-19, all Premiers, Members of Executive Councils responsible for local government in the province, the President of the South African Local Government Association, all Executive Mayors/Mayors and Institutions of Traditional Affairs shall take all reasonable measures to facilitate and implement the measures to the extent provided.

To ensure a well integrated and coordinated planning and response to the COVID-19, the directions provides for establishment of the provincial and district institutional structures. Therefore, the terms of reference are developed in line with the Directions issued by the Minister of COGTA on 25 March 2020 to respond to COVID-19 in the Cooperative Governance and Traditional Affairs sectors.

2. ESTABLISHMENT OF THE PROVINCIAL AND DISTRICT CORONAVIRUS COMMAND CENTRES

2.1 PURPOSE

The purpose of the Coronavirus Command Centres at provincial and district/metro level is to facilitate and ensure implementation of the measures to combat the spread of COVID-19 across provinces and districts at administrative level.

In this regard, the terms of reference will:

- Ensure that national institutional arrangements and structures are replicated at provincial and district level.
- Ensure standardisation of structures to ensure alignment with the Disaster Management Act (57/2002): Regulations and Directives to prevent and combat the spread of COVID-19 in South Africa.

2.2 STAKEHOLDERS

The below-mentioned primary stakeholders mentioned will constitute the Provincial and District Coronavirus Command Centres.

2.3. PROVINCIAL CORONAVIRUS COMMAND CENTRES

(i) Director-General of the Province (Chair)
(ii) Head of Department for Health (Co-chair and content lead sector)
(iii) Head of Department for COGTA (Co-chair and Secretariat)
(iv) All Heads of the Provincial Departments (or delegated DDGs)
(v) Chairperson of the PROVJOINTS
(vi) Provincial Chief Executive of SALGA (or delegate)
(vii) Relevant CEOs of Provincial State Owned Entities (or delegate)
(viii) Relevant Business structures and other relevant stakeholders

2.4. DISTRICT / METRO CORONAVIRUS COMMAND CENTRES

(i) District / Metro Municipal Manager (Chair)
(ii) All Municipal Managers for Local Municipalities (in case of districts)
(iii) Heads of Departments responsible for technical services, community services, finance, communications and public participation
(iv) Chairperson of Cluster Joint Operations Centres (JOCs)
(v) Regional managers of government entities and agencies operating within the district
(vi) Relevant Business structures and other relevant stakeholders

3. FUNCTIONS OF THE CORONAVIRUS COMMAND CENTRES

3.1. The functions of the **Provincial Coronavirus Command Centre** include:

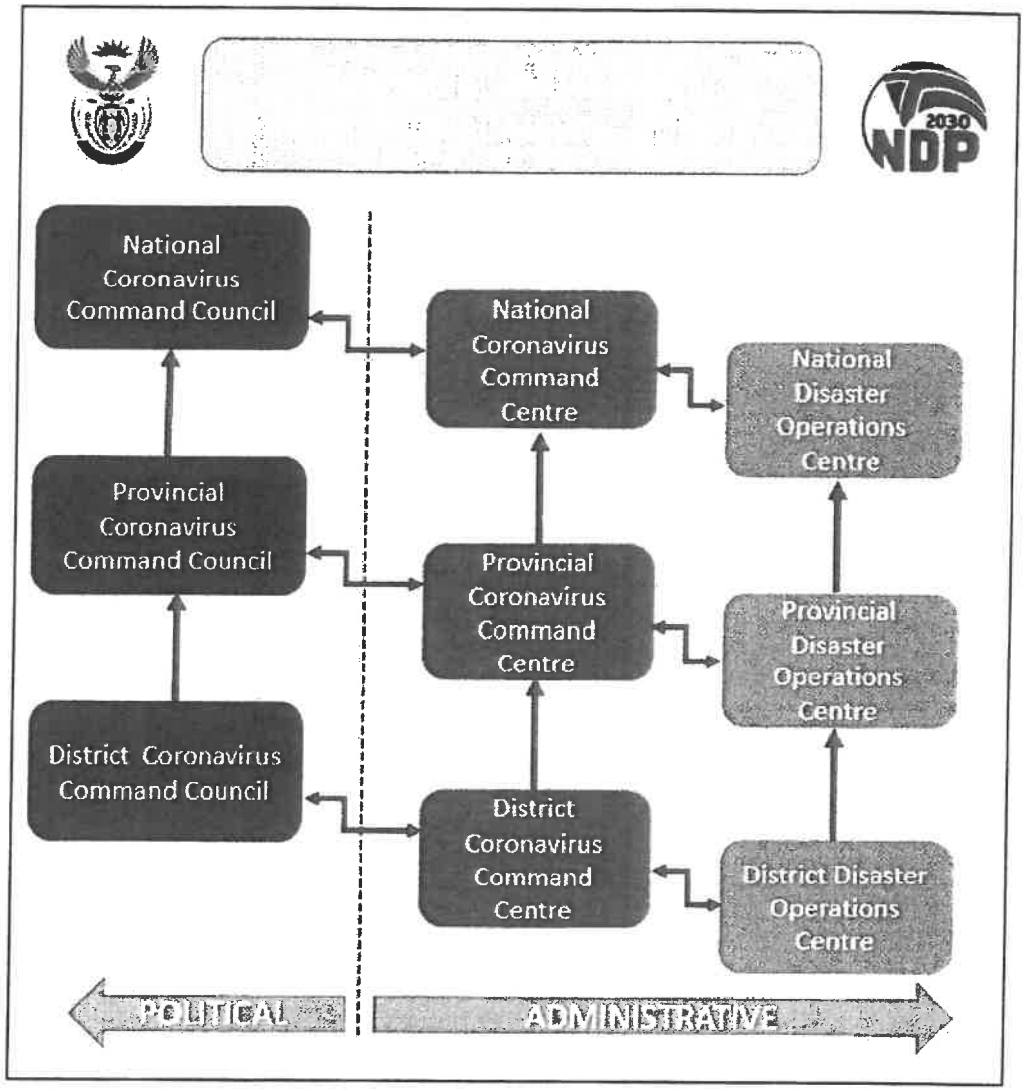
(i) Ensure an integrated and coordinated planning and implementation of the COVID-19 response plans by various sectors at provincial level including private sector and civil society;
(ii) Manage the development and implementation of the provincial COVID-19 response plans;
(iii) Coordinate the implementation of the provincial COVID-19 response plans;
(iv) Ensure the implementation of the Regulations, Directions and guidelines to prevent and combat the spread of COVID-19 at provincial level;
(v) Reprioritise and mobilise provincial resources to respond to the COVID-19 pandemic;
(vi) Ensure activation and functionality of the Disaster Management Operation Centres and other relevant Joint Operations Structures;
(vii) Coordinate the provision of basic services such as water and sanitation, solid waste, temporary shelter, etc. to all communities;
(viii) Ensure availability and functionality of quarantine sites in line with the required standards;
(ix) Submit provincial reports to the Provincial Coronavirus Command Council and other relevant structures; and
(x) Ensure compliance with the National Treasury Regulations relating to Emergency Procurement in Response to National State of Disaster.

3.2. The functions of the District / Metro Coronavirus Command Centre include:

(i) Ensure an integrated and coordinated planning and implementation of the COVID-19 response plans by various sectors at district and metro level including private sector and civil society;
(ii) Manage the development and implementation of the COVID-19 district or metro response plans;
(iii) Coordinate the implementation of the district and metro COVID-19 response plans;
(iv) Ensure the implementation of the Regulations, Directions and guidelines to prevent and combat the spread of COVID-19 at district and metro level;
(v) Reprioritise and mobilise district and metro resources to respond to the COVID-19 pandemic;
(vi) Ensure activation and functionality of the Disaster Management Operation Centres and other relevant Joint Operations Structures;
(vii) Ensure the provision of basic services such as water and sanitation, solid waste, temporary shelter, etc. to all communities;
(viii) Ensure availability and functionality of quarantine sites in line with the required standards; and
(ix) Submit district and metro reports to the District Coronavirus Command Council and other relevant structures.

(x) Ensure compliance with the National Treasury Regulations relating to Emergency Procurement in Response to National State of Disaster

4. REPORTING STRUCTURE



5. REPORTING MECHANISMS

- The Provincial and District/Metro Coronavirus Command Centres should meet atleast three times a week and submit reports to the Provincial Coronavirus Command Council.
- The Provincial Disaster Operations Centre and Provincial Joints Operations and Intelligence structure to ensure that all reports are analysed, consolidated and submitted to the Provincial Coronavirus Command Centre.
- The District Coronavirus Command Centre to consolidate the district or metro reports to be submitted to the District Coronavirus Command Council and the Provincial Operations Centre.



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DEPARTMENT OF CO-OPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

NO. R. 399 **25 MARCH 2020**

DIRECTIONS ISSUED BY THE MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS WITH RESPECT TO THE RESPONSE TO COVID-19 IN THE COOPERATIVE GOVERNANCE & TRADITIONAL AFFAIRS SECTORS

I, Dr Nkosazana Dlamini Zuma, the Minister of Cooperative Governance and Traditional Affairs, hereby, in terms of section 27(2) of the Disaster Management Act, 2002 (Act No. 57 of 2002), issue directions in the schedule hereto, to address, prevent and combat the spread of COVID-19 in South Africa.

NC Zuma

DR NKOSAZANA DLAMINI ZUMA, MP

MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

DATE: 25 · 03 · 2020 ·

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1. BACKGROUND

1.1 In consideration of the magnitude and severity of the COVID -19 pandemic, Cabinet in its special Cabinet meeting held on 15 March 2020, resolved to declare a National State of Disaster, which was duly declared under Government Gazette No. 43096. This was followed by the National Address by the President of the Republic of South Africa, during which address the President announced extra ordinary measures to curb and contain the spread of the virus.

1.2 On 18 March 2020, I issued Regulations in terms of Section 27(2) of the Disaster Management Act, 2002 (Act No. 57 of 2002) (hereafter referred to as the COVID-19 Regulations) regarding the steps necessary to prevent an escalation of the disaster or to alleviate, contain and minimize the effects of the disaster.

1.3 On 23 March 2020 the President of the Republic announced an escalation of the measures to combat COVID – 19, which include an initial 21 Day Lockdown.

2. PURPOSE

To direct municipalities and provinces in respect of the following matters in response to COVID-19:

(a) Provision of water and sanitation services;
(b) Hygiene education, communication and awareness;
(c) Waste management, cleansing and sanitization;
(d) Municipal public spaces, facilities and offices;
(e) Customary initiations and cultural practices
(f) Isolation and quarantine;
(g) Monitoring and enforcement;
(h) Municipal operations and governance;
(i) Institutional arrangements and development of COVID-19 response plans; and
(j) Precautionary measures to mitigate employee health and safety risks.

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3. SCOPE

These Directions apply to all provinces, municipalities, and where indicated, institutions of Traditional Leadership.

4. AUTHORISATION

These Directions are issued in terms of section 27(2) of the Disaster Management Act, 2002 following the Declaration of a National State of Disaster and published in Government Gazette No. 43096 on 15 March 2020 and must be read together with the COVID-19 Regulations published under Government Notice No. 318 on 18 March 2020, and COVID-19 Regulations on the 21-day lockdown period published on 25 March 2020.

5. DEFINITIONS

In these Directions, any word or expression bears the meaning assigned to it in the Local Government: Municipal Systems Act, 2000 (Act No. 32 of 2000), the Local Government: Municipal Structures Act, 1998 (Act No. 117 of 1998), the Disaster Management Act, 2002, the National House of Traditional Leaders Act, 2009 (Act No. 22 of 2009), the Traditional Leadership and Governance Framework Amendment Act, 2009 (Act No.23 of 2009) and COVID-19 Regulations, unless the context indicates otherwise.

'COGTA' means the national Departments responsible for Cooperative Governance & Traditional Affairs.

'Command Council' means the executive authority that has been put in place to oversee the government response to COVID-19.

'COVID-19 risk profile' means a depiction of risk and its subcomponents spatially and temporally with data on the hazard, vulnerability and capacity characteristics.

'COVID-19 Regulations' means any regulations issued in terms of Section 27(2) of the Disaster Management Act No 57 of 2002 in pursuance of the nation-wide response to the COVID-19 pandemic.

'hotspot areas' means high risk areas for spreading the disease considering socio-economic vulnerabilities (such as overcrowded settlements, informal settlements with minimal access to services; high poverty level areas), communal areas, areas with limited

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or no access to water and sanitation services, and areas with high numbers of confirmed infections.

'initiation' means any customary or cultural practice of traditional communities that is used by such communities as a rite of passage to adulthood in respect of male or female children.

'initiation school' means any place where the customary or cultural practices relating to initiation.

'institutions of Traditional Leadership' means those institutions or structures established in terms of the National House of Traditional Leaders Act, 2009 (Act No. 22 of 2009), and the Traditional Leadership and Governance Framework Amendment Act, 2009 (Act No.23 of 2009).

"Minister" means the national minister responsible for the Departments responsible for Cooperative Governance & Traditional Affairs.

'potable water' means water that is treated and safe to drink or to use for food preparation.

'sanitation services' means the collection, removal, disposal or purification of human excreta, domestic wastewater, sewage and effluent resulting from the use of water for commercial purposes.

'social distancing' means limiting personal contact as a measure to reduce the probability of contact between persons carrying an infection, and others who are not infected, so as to minimize disease transmission, morbidity and ultimately, mortality.

'Traditional Leader' means leaders defined in terms of the National House of Traditional Leaders Act, , as amended2009 (Act No. 22 of 2009), and the Traditional Leadership and Governance Framework Act, No 41 of 2003 as amended

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6. DIRECTIONS

6.1. For the duration of the state of disaster for COVID-19, all Premiers, Members of Executive Councils responsible for local government in the provinces, the President of the South African Local Government Association, all Executive Mayors / Mayors and institutions of Traditional Leadership shall take all reasonable measures to facilitate and implement the measures to the extent provided herein.

6.2. Provision of water and sanitation services

6.2.1. **Municipalities are directed to:**

(a) Ensure that communities are provided with the necessary means to prevent transmission, whilst preventing disruptions in services that are rendered through both municipal programmes and customer interaction.
(b) Provide potable water and sanitation services to high population density settlements, rural communities, informal settlements.
(c) Provide other appropriate means, like water tankers, boreholes and storage tanks in water constrained communities that have limited access to municipal water supply.
(d) Ensure that, in collaboration with the relevant stakeholders, water and sanitation is available at public facilities and public transport points.

6.3. Communication, awareness, and hygiene education,

6.3.1. Municipalities and their officials and councillors, as well as institutions of Traditional Leadership, should play an important role in ensuring wide-spread and consistent messaging and communication.

6.3.2. **Municipalities and institutions of Traditional Leadership are directed to:**

(a) Prepare and roll out awareness campaigns on COVID-19, using available media platforms (print, radio, and social media), to the public within their areas of jurisdiction.
(b) Ensure that communication materials include details on prevention methods, identification, infection control, local reporting channels and emergency contacts in order to raise public awareness and encourage appropriate preventative behaviours and practices.
(c) Conduct advocacy and awareness programs on the prevention and

control of COVID-19 and establish communication protocols for the reporting of cases relating to employees, councillors and traditional leaders.

(d) In partnership with the Health Authorities, provide soaps, sanitizers, facial masks, latex gloves and other materials or equipment necessary for prevention of person-to-person transmission in areas where municipal staff and councillors have direct contact at public service centres and facilities (i.e. municipal offices, clinics, etc.)

(e) In partnership with the health authorities, non-governmental organisations, community and faith-based organisations and the business community, provide orientation and information to Councillors, Ward Committees, Community Development Workers (CDWs), Traditional Leaders, Religious Leaders, Expanded Public Works Programme (EPWP) workers and Community Works Programme (CWP) participants to enable them to play the role of health promoters in their communities and enable uniform, non-alarmist and consistent communication with the public.

6.4. Waste management, cleansing and sanitization

6.4.1. The control of the transmission of the virus will require extra-ordinary cleansing and sanitization of public facilities.

6.4.2. **Municipalities are directed to:**

(a) Identify hotspot areas and mitigation measures within their areas of jurisdiction.

(b) In collaboration with relevant health authorities, establish capacitated and well-equipped response teams (e.g. with pressure cleansers and spray equipment, anti-biochemical protective clothing) who could be deployed to provide cleansing and sanitization of places and facilities that could be at high risk for the transmission of the virus.

(c) Share information on the potential hotspot areas with local, provincial and national structures and institutions for integrated responses.

(d) Ensure that the relevant protocols are followed when disposing of hazardous waste (equipment, masks, gloves, etc.).

6.5. Municipal public spaces, facilities and offices

6.5.1. Control measures must be put in place in relation to public spaces, facilities and offices to ensure social distancing to prevent the risk of transmission.

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6.5.2. **Municipalities are directed to immediately:**

(a) Close all public spaces and facilities that do not provide essential services as follows:

(i) Swimming pools – all swimming pools to be immediately closed.
(ii) Beach bathing – bathing at all beaches to be prohibited with immediate effect.
(iii) Libraries – all municipal libraries to be closed.
(iv) Community halls and recreation centres to be closed for community events and functions.
(v) Museums and art galleries – all municipal museums and art galleries to be closed.
(vi) All markets including street vendors must be closed, other than food markets.
(vii) Public parks should be closed.
(viii) Events – all municipal events to be suspended indefinitely.

(b) Monitor social gatherings as follows:

(i) Cemeteries, crematoria and funerals – during funerals, affected families must be encouraged to observe recommended hygiene practices, limit the number of mourners in accordance with the regulations. The handling and disposal of human remains brought about as a result of COVID-19, must be done in terms of the guidelines and protocols that have been developed by the National Department of Health.
(ii) Community gatherings, other than funerals, must be cancelled and stopped immediately.
(iii) Wedding receptions and celebrations must be cancelled for the duration of the lockdown and all periods of restricted movement.

(c) Stop the issuing of permits for marches, protests and the handover of petitions

6.6. Isolation and quarantine

6.6.1. Municipalities are directed to:

(a) Work with the provincial departments to identify suitable quarantine and

isolation sites within their jurisdiction.

(b) Implement provisions for quarantine, self-quarantine and isolation, as guided by the protocols and guidelines of the Department of Health.

6.6.2. Municipalities are directed to:

(a) Monitor and control social distancing in communities.
(b) Work in collaboration with the South African Police Service, South African National Defence Force, and other law enforcement agencies to stop social and public gatherings, other than funerals.
(c) Adhere to the separate regulations pertaining to funerals.

6.7. Municipal operations and governance

6.7.1. Municipalities are required to perform various legislated functions, including the passing of budgets and the adoption of integrated development plans (IDPs).

6.7.2. No Council meetings outside the District Command Centre Meetings may be undertaken during the initial 21 Day Lockdown period, or any other extended period that maybe declared.

6.7.2. Municipalities are directed to:

(a) Comply with the laws prescribing the IDP and budget processes aligned with COVID-19 Regulations.
(b) Instead of convening contact meetings, develop electronic and alternative methods of consultation, agreements and approvals for municipal governance planning and budget processes.
(c) In instances where a council meeting requires more than 100 persons to be present, make appropriate alternative arrangements for such meetings to proceed, which may include the viewing of proceedings from different venues, and then casting their votes in the council chambers in groups, which do not exceed the 100-person limit at any given time.
(d) Consider and adopt their budgets.
(e) Suspend all ordinary council meetings.
(f) Revise their budgets to prioritise programmes and projects aimed at combatting the spread of COVID-19, and the revised budgets must be submitted to the Department of Cooperative Governance before the end of May 2020.

6.7.3. Municipalities are directed to:

(a) Undertake emergency procurement within the framework of the Disaster Management Act, 2002 and the transversal contracts that have been finalised by the Municipal Infrastructure Support Agent prior to the pandemic.
(b) Adhere to National Treasury Regulations and the National Treasury Instruction No. 08 of 2019/2020 dated 19 March 2020, relating to *"Emergency Procurement in Response to National State of Disaster"*.
(c) Report all procurement conducted on an emergency basis, to the first council meeting after the lapsing of the National State of Disaster.

6.8. Institutional arrangements and development of COVID-19 Response Plans

6.8.1. Provincial COGTAs and Offices of Premiers are directed to immediately:

(a) Establish the Provincial Command Council.
(b) Establish coordinating structures at provincial level to support the national institutional arrangements.
(c) Support the establishment of joint operation centres per district and metropolitan municipality.
(d) Avail resources to supplement the capacity of the joint operation centre or the district disaster management centres.
(e) Monitor the impact of interventions and submit weekly consolidated reports to the national disaster management structures.

6.8.2. Municipalities are directed to immediately:

(a) Establish the District Command Council with immediate effect.
(b) Establish coordinating structures at municipal level to support the national and provincial institutional arrangements in collaboration with district and provincial administrations.
(c) Participate in joint district and provincial disaster management structures to ensure a coordinated response to COVID-19.
(d) Monitor the progress and impact of interventions in the municipality and submit weekly consolidated reports to the provincial and national disaster management structures.

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6.9. Development of COVID-19 Response Plans

6.9.1. Provincial COGTAs and Offices of Premiers are also directed to:

(a) Develop and implement a COVID-19 Response Plan for the province with immediate effect.
(b) Monitor and coordinate provincial COGTA's response to COVID-19.
(c) Obtain and analyse district/Metros COVID-19 risk profiles.
(d) Support the district disaster management centres to develop response plans with the involvement of local municipalities.
(e) Monitor and report on the progress and impact of the interventions to the Minister on a weekly basis.

6.9.2. Municipalities are directed to:

(a) Develop and implement a COVID-19 Response Plan within each district/metropolitan geographical space with immediate effect.
(b) Compile a COVID-19 risk profile, including hotspot areas in the municipality.
(c) Monitor and report on the progress and impact of the interventions to the Minister on a weekly basis.

6.10. Precautionary measures to mitigate employee health and safety risks.

6.10.1. National Departments, Provincial governments, Municipalities and institutions of Traditional Leadership are directed to:

(a) Provide frontline staff with the materials or equipment necessary to prevent person-to-person transmission, including soaps, sanitizers, facial masks, and latex gloves.
(b) Prioritise electronic document handling measures to minimize person-to-person transmission through document and stationary handling.
(c) Provide frontline and general staff with training on hygiene and sanitizing of workspaces and on COVID-19 risk identification and response protocols.
(d) Ensure cleansing and sanitising of reception areas / community service centres, offices, lifts, vehicles, biometrics and ablution facilities, and all other objects that are generally touched by persons utilising the facilities, including handles and taps.
(e) Disinfect floor and work surfaces of municipal offices periodically, at least twice-a-day during working hours.

(f) Assign officials (including service providers) who will sanitise hands of people entering public facilities.
(g) Install secured alcohol-based sanitizer dispensers at all points of entry, exit, workstations and in the passages/corridors.
(h) Issue all officials at reception, admission and operational areas with appropriate protective equipment with immediate effect (as per the Standing Operating Procedures of the Department of Health).
(i) Ensure that gloves are sanitised between searches.
(j) Provide bins for the disposal of biohazardous material.
(k) Temporarily suspend the provision of services to the public in instances where there is no sanitising or protective clothing equipment available, other than the provision of essential services, as define by the relevant regulations.
(l) Establish mechanisms for reporting of identified cases of transmission and infection, without raising public alarm and fear.
(m) Provide protective materials and or equipment for prevention of person-to-person transmission for general workers and operators of municipal equipment and vehicles as a precautionary measure.
(n) Ensure that sufficient stock is available for the duration of the national state of disaster.
(o) Direct inquiries about COVID-19 to relevant health authorities, if it cannot be addressed by the municipality.

7. SHORT TITLE AND COMMENCEMENT

These Directions are called the COGTA COVID-19 Disaster Response Directions, 2020 and take effect on the date of signature and shall terminate on the date when the national state of disaster lapses or is terminated.

NC Zuma

DR NKOSAZANA DLAMINI ZUMA, MP
MINISTER OF COOPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS

DATE: 25. 03. 2020

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OPINION

on

CONTAINING CORONAVIRUS

for

THE DEPARTMENT OF JUSTICE

Wim Trengove SC
Adila Hassim
Kerry Williams

14 March 2020

INTRODUCTION

1 The National Department of Justice ("**Justice Department**") seeks urgent advise on which legislation to use to contain the spread of Coronavirus in South Africa. It has instructed us to advise on this issue on an extremely urgent basis, and in a matter of hours.

2 In the circumstances and in order to understand what measures the National Department of Health ("**Health Department**") and the National Institute of Communicable Diseases ("**NICD**") intends to implement, we had a telephone discussion with a senior epidemiologist at the NICD who is drafting the implementation plan for the Health Department. He instructed us that the measures that the NICD plans to introduce may evolve over the course of the day. However at the time of the call (12h15 on 14 March 2020) the implementation plan was as follows:[1]

2.1 Phase 1A – every person entering the country from a high Coronavirus transmission zone will be tested at the airport or relevant port of entry. Those who require hospitalisation will be hospitalised. Those who are positive and do not require hospitalisation will isolate themselves at home if they are able to safely implement the isolation guidelines (i.e. if they have the type of home that allows this). Every person who is tested at a port of entry has to sign a document to say they will self-quarantine for 14 days, which self-quarantine is required to take place at home. There needs to be a penalty for those who do not abide. If somebody is unable to properly self-isolate at home then government will have to provide isolation facilities. These facilities are not likely to be hospitals – as these people are not sick. Again, keeping people in the

[1] He also indicated he would be in contact before 15h00 should anything change materially and we have not heard from him.

self-isolation facilities need to be legally enforceable and may require isolation against their will.

2.2 In phase 1B - there also needs to be a mechanism which requires anyone who entered the country from middle of February (the start of Italian transmission date) from a high Coronavirus transmission zone needs to present themselves to be tested. Further note that for all persons tested at a port of entry they will be required to be re-tested after 7 days. A person who is negative after the 7 day re-test will be released (this is important as the NICD policy decision is to try to flatten the curve);

2.3 Phase 1C – by approximately 23 March 2020 all gatherings of over 200 people will be prohibited. This will affect social gatherings and events like school assemblies;

2.4 Phase 2 – involves targeting communities which may be affected:

2.4.1 The NICD will get testing into all local clinics;

2.4.2 When the NICD identifies so-called "hot spots" then there will be a need to quarantine a community. This will include travel restrictions in the local area which need to be enforceable.

3 We are instructed that Coronavirus is a category 1 notifiable medical condition as it is a "respiratory disease caused by a novel respiratory pathogen".[2]

4 In light of the above, we set out below our views on which legislation is appropriate to use to implement the Proposed Containment Measures. We limit this advice to the Phase 1A and 1B Measures, of compulsory testing of persons at ports of entry and requiring persons who have entered South Africa since mid-February 2020 to present

[2] Regulation 12 of the Notifiable Medical Conditions Regulations read with Annexure A, table 1.

themselves for compulsory testing, as this is what we understand is required immediately.

5 We have reviewed the State of Emergency Act 64 of 1997. For reasons which are unnecessary to burden this opinion with, it is not suitable for the implementation of the Proposed Containment Measures.

6 We are of the view that the Department should use the Disaster Management Act 57 of 2002 ("**Disaster Management Act**") and specifically sections 23 and 27 of this Act which allows for the determination of a national disaster, the declaration of a national state of disaster (in the Government Gazette) and the follow-on issuing of directives and the making of regulations to address such national state of disaster.

7 We further note that when developing and implementing the Proposed Measures, the Department should also have regard to the Regulations Relating to the Surveillance and the Control of Notifiable Medical Conditions, 2017[3] ("**Notifiable Medical Conditions Regulations**"), promulgated under the National Health Act 61 of 2003.

THE DISASTER MANAGEMENT ACT

8 The Disaster Management Act allows for the declaration of a national disaster. A disaster is defined as:

> "*a progressive or sudden, widespread or localised, natural or human caused occurrence which*
>
> *(a) causes or threatens to cause*
>
> *(i) death, injury or disease;*
>
> *(ii) damage to property, infrastructure or the environment; or*

[3] Published in GN 1434, GG 41330, of 15 December 2017.

(iii) significant disruption of the life of a community; and

(b) is of a magnitude that exceeds the ability of those affected by the disaster to cope with its effects using only their own resources" (our emphasis).

9 There is no doubt that Coronavirus is a sudden, widespread, natural occurrence which causes and threatens to cause disease. It is therefore a disaster as defined.

10 Section 23 of the Disaster Management Act allows for the National Disaster Management Centre ("**National Centre**") to "determine whether the event should be regarded as a disaster in terms of the Act, and if so, the National Centre must immediately –

(a) assess the magnitude and severity or potential magnitude and severity of the disaster;

(b) classify the disaster as a local, provincial or national disaster in accordance with subsection (4), (5) and (6); ...

(c) record the prescribed particulars concerning the disaster in a prescribed register."

11 Section 23(6) also sets out that a disaster is a national disaster if "it affects more than one province" or a "single province is unable to deal with it effectively".

12 It seems that the National Centre, based on the facts, must first therefore determine that the presence of Coronavirus in South African as a national disaster. Once this has been done then resort may be had to section 27.

13 Section 27(1) of the Disaster Management Act provides that:

"*In the event of a national disaster, the Minister may, by notice in the Gazette, declare a national state of disaster if -*

(a) existing legislation and contingency arrangements do not adequately provide for the national executive to deal effectively with the disaster; or

(b) other special circumstances warrant the declaration of a national state of disaster."

14 It seems that "special circumstances" warrant the declaration of a national state of disaster. However, it will be necessary to get full instructions from the Health Department and the NICD to ensure that this is the case.

15 Further, it also seems that the existing legislation in the form of the Notifiable Medical Conditions Regulations may also not "adequately provide for the national executive to deal effectively with the disaster" and this would also warrant the declaration of a national state of disaster. However, it will also be necessary to get full instructions from the Health Department and the NICD that this is the case.

16 Assuming that the requirements of section 23(1) and (6) of the Disaster Management Act are met then the first thing that must be done is the National Centre must determine that the presence of Coronavirus in South Africa is a national disaster. Assuming that the requirements of 27(1) of the Disaster Management Act are met then the second thing that the Minister of Cooperative Governance and Traditional Affairs ("**the Minister**") should do is declare the presence of Coronavirus in South Africa as a national state of disaster in terms of this section and publish such declaration in the Government Gazette.

17 Once this is done, it is then permissible to make use of the remainder of section 27 of the Disaster Management Act to implement the Proposed Containment Measures.

18 Section 27(2) provides that:

"If a national state of disaster has been declared in terms of subsection (1), the Minister may, subject to subsection (3), and after consulting the responsible

Cabinet member, make regulations or issue directions or authorise the issue of directions concerning -

(a) the release of any available resources of the national government, including stores, equipment, vehicles and facilities;

(b) the release of personnel of a national organ of state for the rendering of emergency services;

(c) the implementation of all or any of the provisions of a national disaster management plan that are applicable in the circumstances;

(d) the evacuation to temporary shelters of all or part of the population from the disaster stricken or threatened area if such action is necessary for the preservation of life;

(e) the regulation of traffic to, from or within the disaster stricken or threatened area;

(f) the regulation of the movement of persons and goods to, from or within the disaster stricken or threatened area;

(g) the control and occupancy of premises in the disaster stricken or threatened area;

(h) the provision, control or use of temporary emergency accommodation;

(i) the suspension or limiting of the sale, dispensing or transportation of alcoholic beverages in the disaster stricken or threatened area;

(j) the maintenance or installation of temporary lines of communication to, from or within the disaster area;

(k) the dissemination of information required for dealing with the disaster;

(l) emergency procurement procedures;

(m) the facilitation of response and post disaster recovery and rehabilitation;

(n) other steps that may be necessary to prevent an escalation of the disaster, or to alleviate, contain and minimise the effects of the disaster; or

(o) steps to facilitate international assistance." (Our emphasis)

19 The utility of section 27(2) in the present circumstances is that it:

19.1 Allows the making of regulations and the issuing of directives – the latter being quicker to issue;

19.2 Allows the issuing of directives in an incremental fashion – which will allow the Minister to respond as and when new Measures are needed;

19.3 Subsection (f) provides for directives or regulations which regulate the movement of persons within the disaster stricken area. This seems to allow for the Phase 1A Measure of restricting entry into South Africa on condition that the person seeking entry is tested for Coronavirus;

19.4 Further, subsection (g) allows for "other steps that may be necessary to prevent an escalation of the disaster or to alleviate ... the effects of the disaster". The Phase 1A and 1B Measures appear to fall into the category of other steps that may be necessary to prevent the escalation of Coronavirus and steps which may be necessary to alleviate the effects of the disaster.

20 Section 27(3) provides for the constraint applicable to the issuing of directives or the making of regulations – they must always be "*necessary for the purpose of* –

(a) assisting and protecting the public;

(b) providing relief to the public;

(c) ...

(d) ...

(e) dealing with the destructive and other effects of the disaster".

21 It is noteworthy that section 27(4) provides that regulations made in terms of subsection (2) may include regulations prescribing penalties for any contraventions of the regulations. It will therefore not be possible to make use of the power to issue directives to implement any Measure which must be accompanied by a penalty. Having said this, it is still possible for the Minister to issue directives and then thereafter pass regulations which repeat the directives and then also attach penalties to a failure to comply with the regulations.

22 Finally we note that a national state of disaster lapses three months after it has been declared alternatively it may terminated by the Minister before the end of the three month period. This too makes it a useful flexible mechanism.

CONCLUSION

23 On the current instructions and the facts we have available to use at present it seems that the better option for implementing the Proposed Measures is to make use of the Disaster Management Act and the powers conferred by sections 23 and 27.

24 The first step would be for the National Centre to determine that the presence of Coronavirus in South Africa is a national disaster and record the prescribed particulars in the prescribed register. The second step is for the Minister to declare that the presence of Coronavirus in South Africa is a national state of disaster by way of

publication of a notice in the Government Gazette. The next step would be to formulate and develop the appropriate regulations and directives.

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PROFESSIONAL OPINION

Development, rationale, implementation and interpretation of the Disaster Management Act 57 of 2002

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1. Introduction and background

Until June 1994, South Africa did not have a holistic approach when dealing with disasters and issues of risk. In the apartheid years, South Africa had followed the traditional trend that viewed disasters as resulting from "acts of nature" as rare, inevitable events that could not be predicted or avoided. Due to this belief, the approach to dealing with such disasters focused solely on actions that were ***reactive*** – in other words, the focus was only on *post*-disaster measures designed to deal with the consequences or adverse effects of a disaster. Severe events were dealt with under the Civil Protection Act 67 of 1977 (as amended) and the Fundraising Act 107 of 1978. The first act provided for the operations of civil protection at all tiers of government, while the Fundraising Act provided mechanisms for the funding of disaster social rehabilitation. Internationally, however, there was increasing recognition that through better planning, and by placing a greater emphasis on the introduction of development strategies to improve the resilience of communities, the ***risk of disaster*** might be reduced or even eliminated. It was not until the mid 1990s, that the term ***"disaster management"*** became widely used in South Africa to refer to the guiding principles in the management of disastrous situations. In its early development, the body of knowledge and expertise responsible for the safeguarding of lives in the event of a disaster was still vested in civil protection.

The devastating floods that occurred in the Cape Flats in June 1994 and the emergence of the new democracy were the catalysts that heralded the paradigm shift in South Africa in terms of protecting our communities against natural hazards. It is widely acknowledged that the promulgation of the South African Disaster Management Act No. 57 of 2002 (DMA) and the

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National Disaster Management Policy Framework of 2005 (NDMF) placed South Africa at the international forefront by integrating disaster risk reduction into all spheres of government through a decentralised and developmental focused approach. The decentralisation of responsibilities aimed to ensure that the three spheres of government in South Africa incorporated the function of disaster risk reduction in their hierarchical structure. Similar processes occurred in other countries, notably in the Philippines, India and Colombia.

The Act also provides detailed information on the creation of disaster risk management centres and other intergovernmental structures at each level of government. The main thrust of the DMA and NDMF centres around the creation of appropriate institutional arrangements for disaster risk management. It has been argued that the ideals of disaster risk management cannot be achieved without structures to support the myriad of actions involved. These structures relate to the formation of disaster risk management centres— referred to as 'the function of disaster risk management' on each of the three tiers of government as well as the inclusion of disaster risk management activities within various sector departments—called the 'activity of disaster risk management'.

2. Rationale of the DMA and NDMF

The DMA was developed to fill a void in Government's ability to ***proactively*** address issues of hazards, disasters and risk (as opposed to continually responding to events), and to ensure alignment with international thinking and best practices. The main emphasis within the DMA is to address disaster risks through a sustainable development perspective, and to ensure timely action to prevent hazards from turning into disasters, and to mitigate any possible consequences. The DMA was one of the first laws internationally which mainstreamed disaster risk reduction into development practices though the integrated development process. Another focus of the DMA was to ensure that disaster risk reduction becomes a **sector-wide** responsibility (for example see section 25 of the DMA). Therefore, emphasis in the NDMF is placed on the creation of coordinating functions within each sphere of Government with accountability to the highest political authority. The main acclaimed feature of the South Africa DMA, which many governments mimicked, is its universal ability in the management of various slow (e.g. drought) and rapid onset (e.g. flash floods) hazards. The DMA is generic enough to ensure that any type of hazard (or disaster e.g. COVID-19) can effectively be managed. Its emphasis on **multi-sectoral, multi-sphere** and **multi-disciplinary** disaster risk reduction aims to ensure that each sector, sphere and organ of state makes provision for the management of disaster risks within their function. The National Disaster Management Centre (NDMC), Provincial Disaster Management Centres (PDMCs) and Municipal Disaster Management Centres (MDMCs) should exercise a coordinating role. The DMA (in section 2) gives preference to all other laws in South Africa to the extent that they can adequately and effectively deal with the occurrence and consequences thereof. The argument can thus be made that disaster risk reduction should become an integrated part of each and every government function, policy, plan and law.

3. Implementation of the DMA and NDMF

Although the DMA and NDMF was a very forward-thinking law at its time of promulgation, the implementation thereof was less so. Various research projects at all levels of Government (see reference list) highlighted the lack of implementation and the challenges. The main reasons for this limited implementation have been the ***placement*** of the various DM Centres as well as the lack of perceived importance of multi-sectoral disaster risk reduction. The NDMF makes the argument for the placement of the disaster risk management function (DM Centres) within Government structures. The thinking at the time of the development of the DMA was that the National DM Centre will be placed within the **Presidency**, as is the case in most other countries. The escalation of the placement to the other spheres of Government would thus follow (PDMCs in the Premiers Office and MDMCs in the office of the Municipal Manager (not Mayor's office for other legislative reasons)). However, this never occurred, and the NDMC remained within the Ministry of Cooperative Governance and Traditional Affairs. The main argument for the placement of the NDMC in the highest political office is the need for decisive and mandated decisions on issues pertaining to hazards and disasters. The DMA in section 3 makes provision for the DMA to be administered by a Cabinet Minister designated by the President. At the time of the promulgation of the DMA the idea was that the Minister in the Presidency will be given this responsibility and thus the NDMC will be placed within the administration accordingly (in the Office of the Presidency). This argument was supported at the public hearings of the DM Bill in Parliament (chaired by Yunus Carrim) **by all** political parties. The logic in this argument was twofold: a) disaster risk reduction requires integrated and multi-sectoral approaches and the implementation of the DMA can only be done successfully if the placement of the coordinating function (DMCs) are linked to the highest decision-making structure, and b) that the designated Minister will have extraordinary powers in the case of the declaration of a national state of disaster and thus the Minister in the Presidency would be the most appropriate accounting line due to his/her proximity to the President. Therefore, for example, in the event of the declaration of a national state of disaster, the regulations would come directly from the Presidency and not a line ministry. In the years that followed, the implementation was dismal at best. The NDMC was relegated to a section within COGTA with very little powers to ensure the implementation of the DMA across sectors and spheres of Government. The motto of disaster management changed from "Everyone's business" to "Not my business". The current COVID-19 state of affairs highlights the error in the placement of the disaster risk management function within a ministry and not the Presidency.

4. Interpretation of the DMA

The above being said, one still needs to provide an interpretation of the DMA as it currently stands. Such interpretation stems from the historical development path, from the Green Paper/White Paper process, the four drafts of the Disaster Management Bill and the current DMA as amended. I would like to address three aspects: a) the appropriateness of using the DMA to deal with the COVID-19 pandemic, b) the mandate of the Minister of Cooperative Governance and Traditional Affairs to make regulations pertaining to the DMA and c) the establishment of the COVID-19 Command Council.

4.1 The appropriateness of the DMA in dealing with the COVID-19 crisis

The only aspect which would have hindered the use of the DMA in the case of the COVID-19 crisis, would be section 2(1)(b) of the DMA, which states: *"The Act does not apply to an occurrence falling within the definition of "disaster" to the extent that that occurrence can be dealt with effectively in terms of other national legislation..."*. Section 21(2)(e) of the National Health Act 61 of 2003 gives the responsibility of the coordination of health and medical services during *"national disasters"* to the Director-General of the national health department. The above act is silent on any other aspect of the management of disasters or state of disasters, hazards or risks. The National Health Act therefore does not make appropriate provision for the management of a crisis such as COVID-19 and thus the DMA would be the most appropriate act to use.

The flexible nature of the DMA makes it an ideal legal instrument in this case. The DMA is quite clear in defining a disaster as an occurrence which "causes or threaten to cause death, injury, disease...". Emphasis here is on the "threaten to cause...". Since 2002 the DMA has never been used to declare a threatening occurrence as a national state of disaster. A national state of disaster was declared for floods in 2011 and for drought in 2018 and 2020. Several provincial and local states of disasters (for floods, veldfires, droughts and storms) have, however, been declared. None of the previous declared states of disaster were done as a preventative ("threatens to cause") measure. This national state of disaster for Covid-19 is the first time that the preventative and thus disaster risk reduction measures of the state of disaster is used.

4.2 The mandate of the Minister of Cooperative Governance and Traditional Affairs to make regulations

Section 26(1) of the DMA stipulates that the *"**national executive** is primarily responsible for the co-ordination and management of national disasters irrespective of whether a national state of disaster has been declared..."*. However, section 27(2) gives the mandate to make regulations in the event of a declared national state of disaster to the Minister responsible for disaster (risk) management (i.e. Minister of Cooperative Governance and Traditional Affairs). This section also emphasises that the Minister may make regulations after consulting with the appropriate Cabinet member. During the public hearings on the Disaster Management Bill in 2001, concerns were raised as to the possible power vested in the Minister and Premier designated for disaster management, and municipal council once a state of disaster is declared. This valid concern lead to a robust debate in which all parties concluded that the oversight, checks and balances in Government are adequate to ensure accountability. I therefore believe that the Minister is fully within her rights to make regulations pertaining to the national state of disaster subject to a consultative process with the Cabinet member in question. However, section 59(4) of the DMA stipulates that any regulations made by the Minister in terms of subsection 59(1) must be referred to the National Council of Provinces for the purposes of section 146(6) of the Constitution. The "regulations" referred to in section 59 pertains to the compensation of losses (death, bodily injury or displacement) occurring in the course of the performance of any function entrusted to a person in terms of the DMA. Section 59(1) might be misconstrued to refer to regulations

made under the declaration of a state of disaster, which it is not, and never was intended to be.

4.3 The establishment of the COVID-19 Command Council

The establishment of any additional structures to manage a disaster is the prerogative of any sector of Government. The flexibility of the DMA allows for the multi-sectoral management of an event and thus does not prohibit the establishment of any additional structures, not does it prescribe the use of only certain structures in Government. However, one would assume that in a constitutional democracy the checks and balances in Government will, and should, ensure accountability, transparency and good governance. The DMA gives the President the responsibility in section 4(1) to establish Intergovernmental Committee on Disaster Management (ICDM), and section 1.1.1 of the NDMF gives further clarity. Such a committee must give effect to the principles of cooperative governance and aims to being together the spheres of Government as well as other needed role-players. This committee must also report to Cabinet and ensure a uniform approach to disaster risk management in South Africa. The ICDM has been established by the President, however it has never had a meeting (it should meet at least four times per year as per the NDMF). One could thus argue that the oversight role of Cabinet in terms of disaster management has not been functioning as per the law. The COVID-19 Command Council is not the ICDM and should be construed as such. The only issue with the COVID-19 Command Council could be its accountability to the Legislature.

5. International practices in dealing with COVID-19

A number of African countries have also declared the COVID-19 pandemic as a national disaster or state of disaster. In most cases the disaster risk management, disaster management or civil protection legislation was used. **Zimbabwe** declared a national disaster on 27 March 2020, **Malawi** on 20 March 2020, **Botswana** a State of Public Emergency on 3 April 2020. In **Ghana**, the National Disaster Management Organisation Act, 1996 established the National Disaster Management Organisation (NADMO) to manage disasters and similar emergencies. However, the government of Ghana has taken a different approach and dealt with the pandemic under the provisions of their Constitution. The Imposition of Restrictions Act was passed and the President used this law to issue several executive instruments detailing measures for containing the virus. Similarly in **Kenya**, the government has enacted several pieces of regulations by expanding/building on the Public Health Act to contain the pandemic. The president has also issued several executive orders to reinforce these regulations. However, academics in Kenya indicates that the government needs to have an overarching multi-hazard and multi-institutional modalities/measures to address all crises, and their current approach favours working in "silos" which are not conducive for the management of the COVIS-19 crisis. **Vietnam** is widely recognised as a best case study in the management of the COVID-19 pandemic. The Vietnam government early on in the pandemic, established a national steering committee which developed a multi-sectoral response plan, before it even recorded its first positive case. Although the country never declared a state of disaster, the prompt response of Vietnam can largely be ascribed to the lessons they learned in 2003 pertaining to the SARS outbreak. **New Zealand** was very successful due to their

decisive leadership, heeding scientific advice and trusting her population. This country declared a national state of emergency on 15 March 2020. The declaration was made by the Minister of Civil Defence in consultation with the Prime Minister. Similar to Vietnam, the New Zealand government acted swiftly largely due to their experience from the 2011 Christchurch earthquake. The state of national emergency for COVID-19 is the first time such a declaration has been made for the whole of New Zealand. The **German** government did not institute a national state of emergency (although the state of Bavaria did) as it used its powers under the Infection Protection Law of 2001. This gives the government powers to limit some constitutionally-mandated freedoms during an epidemic such as the freedoms of movement, assembly, and the inviolability of the home. However, if stronger powers are deemed necessary, then a state of emergency can be implemented. In **India**, Part XVIII of the Indian Constitution specifically authorises the President (acting upon the aid and advice of the Council of Ministers) to declare an "emergency". An emergency must ordinarily be ratified by the Parliament within a month. The preconditions for an emergency proclamation are strict: there must exist a state of war, external aggression, or an armed rebellion. However, on 24 March 2020, the central government invoked the National Disaster Management Act and declared the COVID-19 pandemic a national disaster.

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