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Authors

Zuma, Thembelihle
King, Rachel
Ngwenya, Nothando
et al.

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Lives Interrupted: Navigating Hardship During COVID-19 Provides Lessons in Solidarity and Visibility for Mobile Young People in South Africa and Uganda

Thembelihle Zuma[*],
Africa Health Research Institute, KwaZulu-Natal, South Africa; Institute for Global Health, University College London, London, UK; University of KwaZulu-Natal, Durban, KwaZulu-Natal, South Africa

Rachel King,
University of California, San-Francisco, California, USA; MRC/UVRI and LSHTM Uganda Research Unit, Entebbe, Uganda

Nothando Ngwenya,
Africa Health Research Institute, KwaZulu-Natal, South Africa; Institute for Global Health, University College London, London, UK; University of KwaZulu-Natal, Durban, KwaZulu-Natal, South Africa

Francis Xavier Kasujja,
MRC/UVRI and LSHTM Uganda Research Unit, Entebbe, Uganda

Natsayi Chimbindi,
Africa Health Research Institute, KwaZulu-Natal, South Africa; Institute for Global Health, University College London, London, UK; University of KwaZulu-Natal, Durban,KwaZulu-Natal, South Africa

Rachel Kawuma,
MRC/UVRI and LSHTM Uganda Research Unit, Entebbe, Uganda

Maryam Shahmanesh,
Africa Health Research Institute, KwaZulu-Natal, South Africa; Institute for Global Health, University College London, London, UK; University of KwaZulu-Natal, Durban, KwaZulu-Natal, South Africa

Sarah Bernays,
Sydney School of Public Health, University of Sydney, Sydney, Australia; Global Health and Development, London School of Hygiene and Tropical Medicine, London, UK

[*]Authors Thembelihle Zuma, Rachel King, Sarah Bernays and Janet Seeley contributed equally.

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The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Janet Seeley
Africa Health Research Institute, KwaZulu-Natal, South Africa; MRC/UVRI and LSHTM Uganda Research Unit, Entebbe, Uganda; Global Health and Development, London School of Hygiene and Tropical Medicine, London, UK; University of KwaZulu-Natal, Durban, KwaZulu-Natal, South Africa

Abstract

We examine data from young women and men in South Africa and young female sex workers in Uganda to explore the inequalities and hardships experienced during the COVID-19 pandemic and investigate the opportunities and ability presented to navigate in a virtual world to build an inclusive supportive future for young people on the move. We argue that against the backdrop of a fragile past, young people who see their today disturbed, tomorrow reshaped and their futures interrupted, need support to interact with their social environment and adjust their lives and expectations amidst the changing influences of social forces.

Keywords

East and Southern Africa; poverty; risk; social connections; support

I. Introduction

In a small town in northern KwaZulu-Natal, South Africa, a young man stands on a road not far from his home, where the phone signal is strong, showing a man in his fifties how to find information on the South African Government website on funding available for COVID-19 relief. The man gives him money for a Coca-Cola for the help. In Kampala, Uganda, a young woman puts on her face mask and slips out of the room where she stays, to meet a man who will pay her extra money because she agrees to ‘live sex’— sex without a condom. She feels confident that she has protected herself from COVID-19; she is no longer thinking about HIV-infection. She desperately needs the money. Just a few weeks into national lockdown in both countries these two young people were navigating their way through a changed world. The COVID-19 pandemic has exacerbated uncertainty for everyone globally. For people used to an ordered existence, a regular income and freedom to travel and interact, everyday life has changed radically. For those for whom daily life held less security, for whom risk, and uncertainty permeate each day, the pandemic has upended assumptions about how risks can be managed, money can be found, safety secured.

Bulamah (2020) writes about how the COVID-19 pandemic in Haiti evokes (recent) memories of other crises and events which have curtailed movement. He observes that for the people in Haiti, opportunity for movement—‘looking for life’—is an essential part of making a living at home and outside the country, while ‘being locked represents both a temporal and existential state: not only the definitive loss of the ability to predict the course of days, but also the end of autonomy to move and get things going’ (p. 232). While plans may be interrupted and the taken for granted daily movements thrown off course, ‘looking for life’ has taken on a new meaning in many places: looking for different ways to make a living; to manage the new reality and perhaps to find a new and different-looking future.

In this article, we build on Vigh's concept of social navigation (2009) to examine how young people in South Africa and Uganda 'sail' in the quite different seas of a world turned upside down by the pandemic: 'Rather than designating a pre-planned movement reflected onto a map, the concept of navigation is intricately tied to the practice of moving across a shifting environment, which emphasizes the construction of tentative mappings and a constant dialogue between changing plots, possibilities and practice' (p. 428/429).

When society is at sea and everyone seems to be launched into uncharted waters, the place from which one starts the voyage can influence whether a person sinks or swims. For young people, whose recent lives have been characterized by fragile livelihoods and pervasive risk, there are few secure resources available to them, which can act as an anchor. Like everyone, they have been plunged into an acute exigent state, defined only by its beginning, the emergence of the awareness of COVID-19, and which is perniciously distinguished by having no evident ending. Added to which, the non-pharmacological interventions put in place to curb the spread are perceived by some to potentially pose an equivalent, if not greater, threat to younger people than the risk of infection, through the negative impact on macro and personal economies as well as mental health. This argument may have particular resonance in the global south (Green, 2020; Govender et al., 2020), where there is less formalized social protection infrastructure and a larger proportion of the population is aged under 30 years than in the global north (stats sa, 2019; World Population Review, 2020; Zuma et al., 2020).

We argue that against the backdrop of a fragile past, young people who see their today disturbed, tomorrow reshaped and their futures interrupted, may find ways to interact with their social environment and adjust their lives and expectations in this time of accelerated change. The ways that they find may need to be continually reinvented and adapted to fit the needs of these changing circumstances; and the structures and processes which may be put in place to nurture resilience need to be responsive to these changes. Sou (2019) has advocated for a move away from 'checklist type' frameworks for disaster recovery and to 'reconceptualise disaster recovery futures, in social and cultural terms, in order to respond to the needs and values of disaster-affected groups' (p. 155). The millions of young people in Africa are not a homogenous 'disaster-affected group', and the impact of the COVID-19 pandemic will be experienced very differently across gender, age and social circumstance. Their experience will be shaped by the resources and support they can access. Rather than the visibility of young people being crafted as negative (a threat to health, a threat to political and social stability), the visibility of young people may instead be conceived of as highlighting individuals with skills to navigate a changed world.

In this article, we draw on data from young women in Uganda and young people in South Africa, who live in very different circumstances, to highlight the importance of the local physical, social and personal context in shaping the possibilities of being supported and staying afloat.

The first cases of COVID-19 were recorded in South Africa and Uganda in March 2020. However, the course of the pandemic has been very different in each country. In August 2020, there were over 600,000 cases recorded in South Africa, in Uganda about 3,000

reported cases. The populations of both countries have experienced lockdown to reduce the spread of infection. It is the impact of the lockdown in the early months of the pandemic, as well as the threat of disease, that forms the focus of this article.

II. Methodology

Description of the Settings

In South Africa, the research site is in uMkhanyakude, a district in northern KwaZulu-Natal province. This area is mostly rural with scattered homesteads with about 50% of the population below the age of 35 years (Mkhize, 2018).

uMkhanyakude is the second poorest district in South Africa, with only about 22% of the population having access to piped water and sanitation (Chimbindi et al., 2020; Sharman and Bachmann, 2019). People in most households depend on small-scale agriculture and remittances from migrant workers (Tanser et al., 2001), as well as government grants and subsidies. In this socioeconomically challenged context, despite the availability of effective HIV care and prevention, the area continues to carry a huge HIV burden (Kim et al., 2020); with young women continuing to experience the highest HIV incidence (Chimbindi et al., 2018).

We draw the data for this article from *Thetha Nami* (‘*talk to me’* in isiZulu), a biosocial peer-led intervention project to integrate biomedical, behavioural and social components to improve the demand, uptake and retention of HIV care and prevention and reduce the burden of HIV in young people living uMkhanyakude (Shahmanesh et al., 2020). The participants in the project are men and women aged 18–30 years.

In Uganda, our data are drawn from the accounts of young women who attend the Good Health for Women Project (GHWP) clinic in Kampala, the capital city. The city has a population of about 1.5 million, made up of a diverse mix of ethnic groups from within the country as well as people from the region (Democratic Republic of Congo, Kenya, Rwanda, Somalia, South Sudan and Tanzania). The GHWP is an independent clinic established in the south of the city in 2008 to provide HIV and other sexually transmitted infection (STI) prevention, care and treatment to female sex workers, their partners and their children in a private, safe location. Since inception, GHWP has also been a site for conducting research on the context and underlying factors of HIV risk, including studies focusing on young women. HIV prevalence among young female sex workers (24 years and under) in Uganda was estimated at 26% in 2016, yet preventive services are limited for these women who are highly vulnerable to STI including HIV, and unplanned pregnancy and are often highly mobile. We draw on data collected from young women engaged in sex work attending the GHWP clinic who participated in the HIV-prevention randomized-controlled trial called ZETRA (short for zero transmission) to assess the effectiveness of a cognitive-behavioural and structural HIV prevention intervention on reducing the frequency of unprotected sex, STI and HIV incidence among young sex workers in Kampala. The participants involved in this study were HIV-negative women, aged 15–24 years engaged in sex work.

The Lockdowns

A ‘national state of disaster’ was declared due to the COVID-19 pandemic in South Africa and from the 26 March 2020, a three-week (21 days) nation-wide lockdown was implemented. The lockdown was extended for a further two weeks until the 30 April 2020. Under this full lockdown non-essential businesses and schools were closed, including tertiary institutions, sale of tobacco and alcohol was banned, with restrictions on large gatherings and movement of people. Movement for essential work required a permit. Other interventions implemented alongside the lockdown included: community education campaigns, establishing laboratory COVID-19 testing capacity, physical distancing, promoting regular handwashing and setting up quarantine sites. In addition, door-to-door screening, surveillance, testing, isolation and contact tracing in the community were implemented. On 1 May 2020, the President of South Africa announced that the lockdown would be eased in stages. By the end of August 2020, the country was under ‘Level 2’ of the lockdown, with movement allowed but continued physical distancing and mandatory use of face masks in public spaces. There was then a phased approach to the reopening of schools.

Lockdown measures began in Uganda on 18 March 2020 when mass gatherings were banned. From 25 March to 4 June, public transport was restricted. A full lockdown, restricting movement outside the home and a night curfew, was put in place on 30 March and lasted until early May 2020. During this time, limited government food relief was distributed, targeting vulnerable communities in Kampala and surrounding areas. While the lockdown was subsequently lifted, advice on physical distancing, frequent handwashing and the use of face masks was retained. By June 2020, most economic activity had resumed at decreased levels including public transport, re-opening of shops, restaurants and hotels, although schools and borders still remained closed (Ministry of Health, 2020). The approach taken to the first six months of the pandemic in Uganda was modelled on the experience of controlling outbreaks of other infections including Ebola and Marburg as well as other viral haemorrhagic fevers, meningococcal disease, cholera and typhoid (World Health Organization, 2020; WHO Regional Office for Africa, 2020).

Methods

In South Africa between March 2018 and September 2019, we used community-based participatory research to iteratively co-create and develop a peer-led biosocial intervention for HIV care and prevention in young people, the resultant *Thetha Nami* intervention has been delivered by 52 area-based pairs of trained peer navigators, 12 men and 40 women aged 18–30 years, engaged in community-based sexual health promotion with their peers living in the intervention areas. The peer-led biosocial intervention consisted of a structured assessment tool to tailor the peer support; provision of safe spaces and community advocacy to create an enabling environment for HIV prevention; peer-led sexual health promotion to improve self-efficacy and demand for HIV prevention; accessible youth-friendly clinical services to improve uptake of HIV prevention; and peer-mentorship to navigate resources and improve retention in HIV prevention. They had collectively reached 8,000 young people with their package of interventions before the first lockdown. On 24 March 2020, the non-pharmacological response to COVID-19 required all *Thetha Nami* face-to-face support

to terminate and for the peer navigation to adapt and become virtual: using telephone calls, SMS and WhatsApp messages.

We set up four virtual Microsoft Teams groups to supervise peer navigators (13 peer navigators per group), led by local social science research assistants (SSRAs). The weekly virtual group meetings covered how to support young people's clinical and social needs remotely using telephone calls, SMS or WhatsApp; provide health promotion; refer urgent clinical issues and respond to COVID-19 questions raised by young people. In addition, two WhatsApp groups were created to provide further support to peer navigators. The first group comprised all peer navigators, social science and clinical teams and were used to communicate study-related issues. The second comprised peer navigators and the SSRAs. This platform was used for urgent troubleshooting of issues arising any time before or after the weekly meetings. The study team also sent weekly voice notes via WhatsApp to recap important points. Detailed notes were captured by research assistants during the meetings, including one virtual group discussion with peer navigators. The discussion was conducted on Microsoft Teams with 10 of the peer navigators to understand their perceptions on the role of schools in the time of COVID-19 to gain insights on how COVID-19 disrupted young people's lives. Between 24 March and 24 July 2020, we conducted 13 virtual meetings with the *Thetha Nami* peer navigators to gather information on young people's experience of lockdown. The data presented here are based on the peer navigators' experiences and perceptions as they continue to virtually support young people in their communities during this pandemic.

In Uganda the ZETRA study, which began in July 2015, provided a combination intervention package to young women sex workers with three linked components that addressed both individual and structural factors affecting health-care use as well as sexual behaviour and reproductive health decision-making: (a) peer group sessions that include health literacy, (b) networking and reinforcement of healthy behaviour using mobile technology and (c) individual cognitive behavioural counselling by a trusted adult. We enrolled 644 HIV-uninfected women aged 15–24 years. The participants were randomly allocated 1:1 to receive either the combination prevention intervention package or standard of care. Participants were recruited from community venues in Kampala and followed for 18 months post-enrolment with data collected at baseline and three times post-enrolment to assess frequency of unprotected sex (primary outcome), repeat HIV testing, unmet need for family planning, incidence of STIs including HIV, incidence of unintended recurrent pregnancies and retention in care up to 18 months post-enrolment (secondary outcomes). The delivery of the intervention depended on face-to-face contact at the clinic, during dedicated group or one-to-one sessions. The trial was scheduled to finish in September 2020, with all women in the intervention arm completing their 18-month visit by that time. When the first lockdown began in March 2020, 177 women remained in the study. Given the precarious circumstances in which many of these young women live, we were concerned about their welfare during the lockdown, as opportunities to make a living and access health care had greatly reduced. We obtained regulatory approval not only to ensure women in need of health care could gain access to the clinic but also to collect information on the participants experience of COVID-19 and the lockdown. Since May 2020, we have engaged with the participants through 15–20-minute telephone calls to find out how they were. When

medication and treatment were required, we provided these at the clinic when transport was restored so the women could access the clinic or through delivery to their homes. During our conversations we asked how COVID-19 and the public health response including the lockdown had changed their day-to-day lives and thoughts towards the future. Participants gave their consent for us to use this information in our research. We draw on those data in this article.

We begin by describing the experiences of the young people in our studies in South Africa and Uganda, before reflecting on how the possibilities for young people's virtual social navigation skills, and the ability to manage their livelihoods and health in everyday life, could result in wider changes in society, including an enhanced visibility and awareness of young people's needs and capacities. This new visibility may yield positive change but could also result in the adverse incorporation into networks and structures that degrade or exploit rather than nurture development (Wood, 2003).

III. Findings and Discussion

The Turbulence of Lockdowns and Fears of Infection: A Changed World

Anxiety was the dominant emotion of the young people in both Uganda and South Africa when the first announcement about the lockdown was made and information on restrictions shared. They worried about the future, fearing being cut off, unable to move freely, making a living and losing touch with friends. In South Africa, the *Theta Nami* peer navigators were also anxious about social isolation. They worried about spending time at home with their relatives (and the closer scrutiny of their behaviour by adults) and the household chores and tasks that they would be expected to undertake because they were stuck at home. All hints of independence that they had hoped for, as they travelled towards adulthood, disappeared as lockdown was enforced. The peer navigators said they were no longer accustomed to being homebound and described the time as 'wasted' because they could not continue with their peer navigator tasks (going out and meeting people) and they felt isolated. They alluded to feeling like '*umahlalela*' a term used to describe unemployed men who roam around the community 'doing nothing'. Yet, the peer navigators were fortunate; they had jobs even though their usual tasks were on hold, they retained contact with the Africa Health Research Institute (AHRI); some volunteered to take part in local COVID-19 screening activities as a way to fill their time. Also, because of the link to AHRI the peer navigators had access to information on COVID-19 and advice on infection control. The skills provided through two virtual COVID-19 training workshops provided information for them to respond to other young people's questions about the pandemic. Yet, these peer navigators said that they observed young people carrying on as normal and by sticking to the rules they expressed a fear of missing out on the social life that others were enjoying. Young people in their communities were not paying much attention to COVID-19 or the lockdown regulations, including physical distancing.

The young women in Uganda expressed anxiety too, about the future and about how they would manage. They had very immediate needs and worries. They described a desperate situation as their livelihood options fell away under lockdown. The numbers of (sex work) clients diminished, and the young women were unable to travel to look for work and they

additionally feared staying out after 7pm (because of the curfew). The bars, where they used to meet clients, were closed. Many had children, and even if the child did not stay with them, they needed to send money to the relative who cared for that child in 'the village'. Their opportunities to meet their responsibilities to others and to even feed themselves had vanished. Urgent concerns were, therefore, not only about their own lives, but where they could get money to send home, and what would happen to their children if the schools stayed shut for many months.

Many of the young women commented that in the past they could count on help from a friend or family member with food or some cash for medical needs, but under the lockdown measures everyone was struggling, and it was difficult to find anyone to help out in an emergency. Few lived with relatives; most rented a room or shared a dwelling with other young sex workers. Some resolved to travel to 'the village' when transport resumed, but there was considerable anxiety that the lockdown would be 'extended again, and again and again'. One respondent who was in her early 20s suggested '*everything is on standstill; everything is dead'*—she went on to say that she did not know where she would be in the next months without a job. Daily survival strategies shifted from more established strategies of helping each other out when money was short; and being able to lean on a friend or colleague in the business in the past, to having nowhere to turn and no one to call because they could not afford the cost of airtime. Not being able to share problems led to greater feelings of isolation and increased the already heavy burden of worries. One young woman mentioned how she would think of asking a friend for some food only to discover that that friend was actually worse-off, and she felt she had to help her instead.

In both countries young people stressed the importance of their social connections. In our conversations we often felt their overwhelming feeling was one of helplessness given these networks were at risk due to lockdown restrictions. As Roy (2020) argues, in low-income settings this has taken people off the roads, out of city centres and commercial hubs and contained them within their neighbourhoods and often cramped homes, enforcing `physical compression on an unthinkable scale'. In South Africa, the material struggle was evident, but so too was the fracturing impact on young people of their interrupted journeys into adulthood. Many forced back into their family homesteads, had collectively lost the independence and anonymity that public spaces and increasing autonomy of adolescence ordinarily allows. Forced to live their constricted daily lives within physically crowded spaces exacerbated the social density, creating heightened opportunities for surveillance, social judgements and interpersonal violence.

For the women in Uganda, all aged under 24 years old, these narratives of loss were stark because of the fragility of their circumstances. They described not being able to help friends because of lack of work, not being able to rely on friends because they also did not have work, of not knowing when they would be able to see, greet, help friends.

The tools that young people had previously relied on to navigate their social lives and livelihoods no longer worked as well. Building on the nautical metaphor, in order to cope, young people had to learn to 'tack', a concept coined by Amit and Knowles (2017) to add an additional dimension to social navigation, of improvising and managing the unexpected.

Staying Afloat in a Changed World: Navigating Using the Smartphone

For Amit and Knowles (2017: 167) 'tacking' 'is creative but modest in its immediate ambitions, when faced with uncertainty, people try to improvise in response to new information or changed circumstances, to get by, rather than to radically challenge the structures through which they are navigating'. There is also another dimension of 'tacking' which is also useful as a concept to think with—drawn from needlework rather than sailing—the act of fastening together two pieces of fabric temporarily. Much has been made of the way pandemics pass, and COVID-19 will also pass, yet some things may be changed forever in the 'tacking' that has been done to navigate a way through the lockdown and disease threat (Black, 2020).

Access to a smartphone, which can connect to the internet, has provided a way to communicate for many people during the pandemic; these have proved to be essential instruments in navigating a world where close contact is out of bounds. Under the conditions of lockdown, there is a radical expansion of the significance and consequences of these spaces of sociality. Drawing on Archambault's (2013) ideas around social navigation, we consider the light and shadows cast by the consequences of virtual connectedness and visibility on participants' negotiations of identity, harm reduction and risks.

In South Africa, prior to the lockdown, peer navigators often encountered young people during a game of soccer or in a local shop or water collection point and expressed concern over the difficulty of working out how to engage through remote virtual platforms. Peer navigators were encouraged to use smartphones and were provided with airtime/data for work to be able to connect to the young people they supported in *Theta Nami*. However, they complained that physical contact was essential because many young people could not afford airtime and data to connect or had poor network coverage in their local area. Even though, over time, the peer navigators were able to reach and engage with the majority of those young people with whom they had established connections through *Theta Nami* before lockdown, there were many young people who were not part of the study and who did not have a smartphone and/or data, who had difficulties engaging and obtaining current news on COVID-19 through reliable sources.

In Uganda, young women from ZETRA described similar situations suggesting that their social lives were on hold because they could not meet their friends or even call them on the telephone. One of these women, in her early 20s, mentioned that they would get beaten by members of the local civilian defence units if found standing next to a friend and talking. Other young women said that in their densely populated neighbourhoods they were fearful of visiting their neighbours as they might be accused of transmitting the virus to them. They said they felt under scrutiny because sex workers are known as being mobile and typically meet many people. The women participants in ZETRA that we spoke to on the phone had come up with various strategies to fit their own circumstances which enabled them to cope and rework how they navigated the rules to moderate the risks of compliance and the penalties of transgression while making some money from sex work. One young woman said that she could sneak out at 7 pm to meet a customer and be back by 8 pm, as enforcement in the place she stayed at only began after 8 PM, so called 'deep curfew'. Another woman described how she and six other young women she shared a house with

collaborate to receive customers one at a time in the afternoon hours. They did this in secret as most neighbours were out at work during the day and returned in the evening before curfew. Some other young women discussed how they have been relying on regular customers who know them and where they live.

The smartphone as a navigation instrument has no singular consequence, instead as a navigational device it facilitates a diverse range of possibilities which can both reduce and exacerbate potential harms. The multiplicity of options that this navigation tool provokes, in the context of lockdown, are moderated by how reliance on it in times of disruption and urgency reframe who and what becomes visible or invisible. We argue that this framing elucidates the experiences of those who benefit from engaging in a virtual network to find support, which can augment their social connectedness to facilitate resilience. Even though physically separated, being able to connect with others virtually through the phone means that they could be socially ‘seen’ by others, by having one’s needs recognized and validated through supportive dialogue, even if the immediate physical needs cannot be met. Importantly, by making the time ‘social’ it was considered productive, transforming it from being interpreted as wasted, empty time to being endowed with a value which was meaningful. The phone enabled young people to maintain and develop their social network to navigate towards supportive structures and access reliable COVID-19-related updates and thereby building social capital with positive consequences.

For the Ugandan cohort of women, a phone enabled them to circumvent some of the physical restrictions on where they can solicit clients, by arranging appointments over the phone. However, relying on phones to negotiate the conditions of the sex transaction, rather than being able to do so face to face, compromised their ability to exert a degree of control over the location and appraise the risks which might be posed by a new client. Now, unable to operate as usual, the spaces where they met clients were not necessarily visible to their peers, diminishing the protective surveillance of the informal safety nets that had been in place. Their adaptive strategies to continue to earn an income in these changed circumstances entangled them in a tighter knot of risks as sex work was pushed further into the temporal, social and physical edges. Resonating with Shahmanesh’s (2009) description of the consequences for sex workers of the demolition of a red-light district in Goa, the social context that emerged under lockdown required women to engage in less protected, dispersed and clandestine modes of operation which are less conducive to HIV prevention.

Another illustrative example of the catalytic and multifarious effects of the phone as a navigation tool were the increasing reports of instances where participants were forced to pursue opportunities which fostered ‘adverse incorporation’. In Uganda, the women accepting to meet clients in secluded places, or for less money because of desperation, face threats of violence if they did not provide additional services for no extra pay. In South Africa, there were also heightened possibilities for young people, reliant on their smartphones for communication, to become enmeshed in exploitation and bullying through virtual fora, as well as similar risks faced by the young women in Uganda, in needing to use sex to leverage resources to survive. These capital bonds bind individuals into dangerous relational and physical spaces; conditions which flourish under lockdown.

As Archambault argues (2013) the phone has long been considered pivotal in shaping how people imagine, experience, and navigate material and social spaces; ‘playing a fundamental part in the way young people navigate everyday life’ (p. 98). This current crisis indicates that the phone has shifted from being a desirable to a ‘necessary’ navigation tool to be ‘visible’ and access material and social resources. Yet, although the phone facilitates forms of ongoing connectedness, it also enables and extends the shadows of private spaces which can pose substantial opportunity and risk to young people as they attempt to find their way through the social and economic challenges of life during the pandemic.

‘Staying in Touch’: Knowledges Facilitated by Smartphones

Using the phone to maintain or extend virtual connections was commonly described as the primary means for people to ‘keep in touch’. For the Ugandan women, this had a literal translation enabling them to arrange opportunities to physically meet to have sex with their clients. Forced away from public spaces where their work could be done under the protective darkness of anonymity and into shared private spaces, there was an increased scrutiny rendering their engagement in sex work more obvious to their neighbours. The limited privacy that accompanied being compressed into living in tight physical spaces resulted in being ‘at home’, throughout the day and night, and meant that physical intimacy could not be so easily concealed. Even if this tacit knowledge had existed before, the pretence to ignorance is threatened by such overt evidence. Lockdown can expose, beyond refute, intimate knowledge of others’ lives and disrupt the complex duality of reputation management and the need to ‘get by’, disrupting the reproduction of what Archambault (2013: 89) characterizes as the ‘epistemologies of ignorance’.

For the young people that we spoke with in South Africa, their experience of how phones facilitated ‘staying in touch’ was more metaphorical. Access to social media provided information to supplement, but often also circumvent the news channels on the television and radio. Ready access to these sources of information was not without challenges. Most of the information shared on COVID-19 on the media was not available in their local language or explained in a way that was easy to understand. For example, some peer navigators said that the news channels on the television referred to ‘flattening the curve’, which was a difficult concept to understand, not only by themselves but by most people in their communities. Both younger and older people living in the areas where the peer navigators worked said that they could not understand the timing of the easing of lockdown restrictions. The peer navigators said that as cases began to be identified in uMkhanyakude they, and people in their neighbourhoods, wondered why the economy and schools had been closed before when there were no cases and they were opened when cases began to increase? Rumours spread on social media that this was because the government wanted to get people infected. Peer navigators observed that people were wondering why the government was waiting for a vaccine when there was news being shared that there were traditional medicines that could treat COVID-19 symptoms (*umhlonyane*), and there were also videos circulating on social media about zinc curing COVID-19 and other over the counter medicines known to treat the symptoms.

Similar stories circulated in Kampala on social media, and also in the stories shared between neighbours, fuelling uncertainty about the pandemic and the reasons for the lockdown. The enforcement measures put in place to ensure people adhered to the restrictions increased their sense of fear and uncertainty. The young women we spoke to on the phone talked of a fear of everyone, because there is no way to know if friends or customers are infected and nobody knows if they themselves are infected. They told us that this made them very afraid. Yet there was also fear around the enforcement of the non-pharmacological measures that had been put in place. One young woman commented during a call with one of our team that it was essential to follow the instructions otherwise the Government would keep extending the lockdown if people did not follow the rules: 'We should continue washing our hands, stay home, keep social distance, then we may change something.' Learning the rules; and being seen to keep them, was essential for young women who were very conscious of their marginal position in society. However, sex work required being physically close to earn money, to feed families and pay rent. One 18-year-old woman summed this up: 'I cannot survive without being with people. I must be with people and that is no longer accepted. I need to look after my family, but I can no longer do it now'.

Contagious Discourses of Risk: Infection, Testing and Isolation

At the time of data collection participants were still awaiting the first waves of infection to arrive in their neighbourhoods. COVID-19 was present through anticipated fear and the collateral damage of prevention. In the absence of experiential knowledge, the risks of COVID-19 were appraised using the tools developed through previous epidemics. This was an important reason why many people in Uganda took the lockdown very seriously: there had never been a lockdown of the whole country because of other epidemics, such as Ebola or HIV. It was assumed that COVID-19 must be much more deadly than those infections. The fear of the unknown, the hidden infection, resonated with people's knowledge of HIV and to the confusion over the nature of COVID-19. HIV-infection can remain symptomless for years and is incurable; many people have assumed that COVID-19 is the same, remaining in the body forever. The misalignment between current information and prior understandings of disease risk rendered young people ill-equipped to benefit from the deluge of information. Tools used to support survival through prior epidemics were being deployed again and yet they were inappropriate to respond to the novel nature of the COVID-19 pandemic. The confusion evoked through the rapidly evolving language to describe the infection risk of the virus and necessary prevention measures, coupled with the rapid diffusion of information through social media, created significant challenges. Some participants in both countries described assessing their own risk of exposure to COVID-19 through the prism of their understanding of previous epidemics to assess what it was 'safe' to do.

Fear of the unknown was compounded by the lack of a way to find out if a person was suffering from COVID-19. Tests were scarce in Uganda at the time of data collection. In South Africa, where government testing centres had been publicized on national media, people in uMkhanyakude said they were unclear how and where COVID-19 testing was actually conducted in their area, and this fed anxiety over the methods used for testing and the time taken to receive results. One peer navigator reported that she was approached by a

group of people who worked at a local butchery who asked her if all COVID-19 tests were painful. They told her that staff members at this butchery had refused to test using the nasal and mouth swabs because of the pain they caused. The peer navigators reported that the pain of the testing procedures was being given as an excuse by people experiencing COVID-19 symptoms, as to why they preferred to self-medicate and not go to a clinic or private doctor. This in turn affected the number of cases reported, fuelling fears of hidden cases and the number of people who may be flouting the rules and failing to self-isolate, when COVID-19 was not confirmed, it was treated as a 'normal flu' and people did not have too self-isolate.

The peer navigators also reported that people in their communities complained that it took a minimum of 14 days to receive results. During this time, a person was expected to remain in isolation, in a place that no other family member could use. This was reported to be very difficult for most families. Physical distancing was impossible in small homes where large family groups were locked down together. There was no place to self-isolate where family members were sharing bedrooms and beds.

The peer navigators in South Africa looked to the *Theta Nami* leadership, for accurate information on COVID-19 and advice on what to do. All of the young women that we were able to contact in Uganda were keen to receive advice from the study staff. They also showed faith and belief in the importance of the restrictions and advice of the government and health workers; perhaps this was one anchor to trust and hold on to when many others had drifted away. All participants could recite the basic COVID-19 prevention recommendations which had been shared over the media and claimed to be implementing them as well as they could. They commented that it was important that borders were closed so that outsiders could not continue to bring in more cases of the virus, since the early messaging from both governments was that this was an infection carried by foreigners.

Impeded Access to Healthcare: Staying Well

Despite the trust in health care workers they knew, young people in both countries feared going to public health facilities. Adherence to anti-retroviral therapy (ART), the treatment which prevents HIV-infection from turning into AIDS, was affected for some young people, this was because they could not reach their usual clinics once the lockdown was announced. Two of the peer navigators reported assisting other young people in their communities to access HIV treatment through the clinical team that they worked with. The young people from their local community had approached them because they feared their families finding out they were on ART or feared being chased away at their home clinic because it was not the clinic they normally used when they were away from home studying or working. These fears seemed to be as great as the fear of infection which might occur while waiting at a health facility.

In Uganda the health services have been difficult for the young women to access both due to lack of public and private transport during lockdown and because, unlike in South Africa where clinics remained open, lower-level health facilities were closed. The young women in Uganda reported an inability to access antenatal care, family planning and condoms if they could not walk to larger hospitals. These women, reported their lives in all areas, including maintaining their health, as 'on standstill' while the COVID-19 containment measures

remained. They increasingly had to rely on private clinics for health services, yet these were often unaffordable. Where possible they reported that they helped each other to buy needed medication from private facilities. One young woman in Uganda told us during one call that: ‘I developed malaria, but my friends were there for me. One could come and buy me things to eat, others gave me money to buy something for the baby. My friends helped me out and I bought the drugs from a nearby private clinic’.

Some participants in Uganda had received food distributed by the government in the early days of the lockdown. Those who had missed out complained that the food distribution relief was not well coordinated. Some also reported that the quantities provided were often small and only lasted a couple weeks or they did not have money to buy charcoal which they needed for cooking and they had other unmet needs such as paying rent and worrying about their children’s education.

In South Africa, at the beginning of the first lockdown the government put aside some funds to assist those who were unemployed and those who had lost employment because of COVID-19. In their communities, peer navigators were approached by community members who wanted to know how to access these funds. These young people were also asked to help their neighbours fill in the online application as many people in the communities were not familiar with using such platforms for government-related services and many people do not have smartphones. Peer navigators used their own phones to help those who needed assistance.

Threads of Hope in Uncertainty and ’Tacking’ Them into Opportunities

A few young people, in South Africa, mentioned positive aspects of their experience of being ‘locked down’ with family members they had not really known before who they had grown closer to as they stayed close to home. Some had enjoyed doing errands for family members and helping with gardening or tasks in the house. However, none of the women in Uganda expressed any pleasure in being locked down; we heard joy in some women’s voices when they answered our calls from their ‘village’ having been able to travel out of Kampala as transport restrictions eased. Poverty in the rural homes to which they had travelled and staying with family members who may have been reliant on the income that they sent from Kampala was not easy but at least there was often some food there. For those unable to travel, life even when restrictions eased remains hard. Selling sex is now even more difficult and high risk than it was before COVID-19. Not only had the venues for meeting clients practically disappeared, with the closure of bars, but clients had very little disposable income making it harder for the women to find men seeking sexual services. Some women mentioned taking up house cleaning or making food for sale, others were trying to start a small business selling tomatoes or other vegetables, which compared to previous earnings selling sex, provided little money. One woman described it as ‘a waste of time’, but she had no alternative. Others shared stories of initiating used shoe selling on the roadside, and how sellers help each other by whistling when police are making their rounds to `harass’ roadside businesses. All these options make less money than sex work but provide something to survive on during a time when, as they have lamented, their lives were on hold.

While peer navigators in South Africa complained of not spending time with their friends, they were thankful that they could still connect with a few friends and the world at large through their phones. As we note above, they were fortunate to have access to smartphones and to data. Many other young people in South Africa and the young women in Kampala could not sustain their links; they could not afford to be connected virtually. A stark reminder that the much lauded shift to virtual platforms throws into stark relief the digital divide which cuts many people off from contact (Ramsetty and Adams, 2020). Keeping in touch over the telephone and through social media requires investment, but is essential to stay in touch (Tindana et al., 2020) and can provide new avenues for income (Archambault, 2013).

In uMkhanyakude, there is potential for the virtual peer support mechanism to ameliorate the harms exacerbated by the COVID context. If, for example, interventions such as *Theta Nami* can be provided with the appropriate tools, such as phone data, training, and the ability to make referrals to reliable clinical services and facilitate access to social welfare, they were likely to be able to support young people to help them keep their collective and social identities alive. Such interventions are critical to help young people survive materially and mentally. Although the circumstances of the Ugandan women and the young South African participants are distinct in their differences, the accelerating divergence in the experience of social solidarity and vulnerability over the course of the pandemic may in part be explained by the capacity of *Theta Nami* peer supporters to be able to continually access their job, have phone data and tablets, receive training and participate in regular virtual small group meetings which foster forms of solidarity, resilience and productive connectedness. Whilst they experience many substantial material and emotional challenges, this may help them to navigate the acute uncertainty caused by the disruptive consequences of the COVID-19 pandemic.

The South African case study illuminates the enormous potential of being able to provide support virtually, independent of someone’s proximity to a physical location. While we highlight the potential opportunity of virtual peer support for helping youth to navigate uncertainty, we also illustrate how this has not yet been fully realized because the communications infrastructure, in which airtime is subsidized or toll-free numbers for intervention delivery, to convert this intention into action and experience is missing. Unable to now meet face to face, many vulnerable young people cannot afford to access the virtual social and informational networks. Although the *Theta Nami* peer navigators were supported to purchase phone data, if beneficiaries do not have the cash to buy data too, they will not be able to engage. This inequity of access will be felt unevenly and may further disadvantage already acutely marginalized youth, if we neglect to attend to this limitation. Young people need structural interventions that support jobs and access to ways to earn, as much as access to healthcare. Young people are less likely to be harmed by COVID-19 and most likely to be harmed by school closures and skill loss.

Future interventions may need to incorporate a blend of virtual and physical support to best meet the needs of young people. This design has the advantage of being able to shift delivery mode should physical interactions again be severely limited either through local lockdowns, political disturbances or future epidemics. We argue that it is vital to develop interventions

informed by valuable learning revealed by the first wave of the current crisis. This should involve investing in infrastructural support in toll-free numbers so that all young people can initiate protective connections.

A second key learning from our analysis is the myriad of needs and concerns that young people have which shape their adaptation to this unfurling 'storm'. As Sou (2019) argues, engagement with what support is needed to achieve sustainable resilience in the context of recovery requires recognizing and incorporating the needs of the local population, including what might be deemed outside of the standard parameters of health, such as job security and the construction of 'productive' identities. Considerations that might be deemed 'peripheral' sociocultural needs may be central when attending to how lived experiences reveal individuals' priorities. Broadening our scope is essential to developing a sustainable agenda of harm reduction.

There is divergence across the two case studies in the continued capacity for income generation. In Uganda, the adaptation required heightened existing risks of their occupation and their inherent invisibility. For the *Theta Nami* peer supporters in South Africa, continued access to paid work was a lifeline which not only brought material benefits but may have been socially protective in galvanizing an individual and collective identity predicated on a role in their communities and households. This illustrates the value of investing in structural interventions which support the capacity of young people to continue to earn an income during periods of crisis. Aligning with Liao's (2012) argument and extended by Sou (2019), we argue that supportive interventions must be orientated towards meeting the needs of communities to sustain their resilience. This includes (but is not limited to) being able to adapt and reduce the harms of a pandemic, attending to intangible non-monetary resources such as connectedness and protection that emerges from engaging and being valued in socio-cultural networks.

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