SOUTH AFRICAN BASELINE REPORT JANUARY 2023

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Contextual overview

South Africa is considered a middle power in international affairs, maintaining significant regional influence as a member of international organisations such as the Commonwealth of Nations and the Group of Twenty (G20)[1]. It has been classified by the World Bank as a newly industrialised country and has the third-largest economy in Africa, ranking 109th on the Human Development Index[2].

Like many African countries, South Africa has a young population, constituting 37% of its total population (19.1 million). However, young people struggle in the labour market with unemployment reaching 63.9% for youth aged 15-24, and 42% for those aged 25-42 in 2022. The national rate stands at 34.5%. Although graduate unemployment remains low, the general unemployment rate, irrespective of education, remains high.[3]

Gender inequality is a critical issue, with many women subject to gender-based violence (GBV) in the form of rape, sexual harassment, sexual abuse[4]. Despite a progressive Constitution that protects against discrimination based on sexual orientation or gender identity, the LGBIQ+ and transgender communities continue to experience discrimination and violence as their rights and freedoms are curtailed through hate speech, violent attacks including killings, and threats.[5]

Sex work, either in the form of buying or selling sex, is currently criminalised, and those caught in an unlawful sexual intercourse are regarded as guilty of an offense. This has contributed to the reluctance of sex workers, who are at high risk, to seek treatment and care for HIV. This is exacerbated by punitive laws, stigma, discrimination, and institutional policies, making it difficult for sex workers to protect their health and wellbeing[6]. Drug users are also at higher risk of contracting HIV and due to the criminalisation of this activity, also experience challenges seeking and accessing healthcare services[7].

The **healthcare landscape** itself, a two-tier public and private system, has been described as "unequal", creating divisions between those that can afford quality healthcare and those who cannot. The public system, funded by the Government through taxation, caters for 71% of the population. Yet services are underfunded, poorly managed, and overcrowded, with long waiting queues. The private sector is funded by individual contributions through medical schemes and health insurance, and caters for only 27% of the population, usually upper and middle-class families, and expats. The unequal nature of the healthcare system keeps the vast majority of South Africans, i.e., poor black people, from accessing quality, and affordable healthcare services[8].

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1 Cooper, A. F, Antkiewicz, A, & Shaw, T. M. (2007).

2 Lynch, D. A. (2010).

3 Statistics South Africa. (2017).

4 . UN Women. (nd).

5 Civicus. (2021).

6 UNAIDS. (2021).

7 UNAIDS. (2021).

8 Rensburg, R. (2021).

Civic space is classified by CIVICUS[9] as obstructed due to the deteriorating nature of civic freedom and expressions. Their 2021 report, People Power Under Attack, revealed that South African society continues to deteriorate due to civic space restrictions, detentions, harassment, and the use of excessive force against protestors[10]. HURISA found that, although freedom of expression and peaceful assembly are protected in the Constitution, there are still many challenges and obstacles faced by individuals and civil society organisations (CSOs) seeking to exercise those rights. The most significant challenge for CSOs is access to resources. Additionally, those CSOs that have spoken out against authorities have been hacked or members killed, making people feel unsafe and unprotected by the Constitution and Bill of Rights. Although these two documents protect freedom of expression, they are restrictive in the sense that the Government tries to curb peaceful demonstrations and the right of civilians to demand honest, transparent, and accountable leadership.

Digital access in South Africa is considered wide. It is estimated that more than half of the population has access to the internet. According to a 2022 report[11], internet penetration in South Africa stands at 68.2%. This means that more than 41.19 million South Africans, out of the 60.40 million population has access to the internet, putting the figure of those that do not have access to 31.8%, which is still notably high. South Africa ranks 5th for using internet on mobile phones globally, and above the global average for speed connection[12], though there are limits to this due to low English literacy rates. The high internet user rate means that South Africans have significant access to information via social media or other networks, with approximately 28 million South Africans on social media, including YouTube, TikTok, Instagram, LinkedIn, and Facebook. Using digital devices, South African youth have become digital citizens, using the internet for activism and social change. For example, #RhodesmustFall, #FeesmustFall, #ZumamustFall.

COVID-19 context

South Africa's response to the COVID-19 outbreak has been described as a standout within the continent[13]. Its first cases were confirmed in March 2022[14], and both local and national channels were utilised to attempt to provide information to reduce the spread of the virus[15]. The State's initial response was to impose a nationwide lockdown and put in place comprehensive local public health response mechanisms. The President announced a state of disaster in line with the Disaster Management Act and formulated a risk-adjusted strategy with five levels, which determined the intensity of transmission within the country, with the fifth representing the highest form of local-to local transmission.[16]

Vaccination of the population has been prioritised, with the Government acknowledging the importance of vaccines in stopping the spread of the virus, protecting individuals by reducing people-to-people transmission and thus enabling population immunity. The Government developed a vaccine rollout strategy to guide, oversee and distribute safe, efficient, and quality vaccines to

9 HURISA (2015).
10 CIVICUS (2021).
11 Kemp, S. (2022).
12 Brocklebank, D. (2022).
13 Devermont, J. & Mukulu, T. (2020).
14 Giandhari, J., et. al. (2020).
15 International Monetary Fund. (2021)
16 World Health Organization. (2021).

provincial government and allocated vaccination sites.[17] An Electronic Vaccination Data System (EVDS) was set up to record and input vaccination data. All vaccinated persons are given vaccination cards and electronic certificates. Currently, South Africa records an average of 310 COVID-19 cases a week, with a weekly death toll of 7.43[18]. According to Our World in Data, more than 19 million people, representing 33.1% of the population have been vaccinated[19], with the Government reporting that the country has reached 70% COVID-19 vaccination coverage (at least one dose) for people over the age of 60, and 65% of fully vaccinated adults (50 years and above). More than 1.8 million children have been vaccinated however the biggest challenge has been convincing young adults, (18-34 years) to vaccinate. Those aged 34-49 have also been hesitant due to fake news and misinformation. Undocumented people are also underrepresented in vaccinations as they cannot be clearly identified within the population, have issues of mistrust in Government policies, a fear of punishment if their information and location are exposed, and negative perceptions of the vaccines[20]. Although these groups of people have been underrepresented in vaccinations within South Africa, the State is still focused on achieving the 70% global target by the end of 2022[21].

However, the vaccine drive in South Africa is running out of steam. In 2020 and 2021, it was recording a daily vaccination of about 240,000. However, the number has reduced to about 5,000 vaccinations in 2022. Most vaccination sites have been closed and in the private sector, it is no longer has viable to operate vaccination sites as they were during the mass uptake. Further, COVID-19 testing, and diagnoses has been extremely low throughout the country. Although the impact of the pandemic seems to have died down, it is important that vaccine boosters are encouraged, especially for those that may have taken the first jab. Further, those with immunocompromised health problems like HIV should be vaccinated against the virus.[22]

Funding for the COVID-19 response has come from national budget allocations, loans from multilateral development banks, including the International Monetary Fund, the African Development Bank, the New Development Bank, and World Bank Group of Executive Directors[23]. In 2020/21 and 2021/22, the Government allocated an amount of R10 billion. Another R2.1 billion was invested into the treatment of communicable and non-communicable disease programmes.[24] The South Africa Medical Research Council also received a R100 million injection for vaccine research, and the Government Communication and Information System (GSIC) is presiding over a R50 million allocation to run mass communication campaigns around the vaccine rollout. In 2022, the Government requested 454.4 million Euros (US480 million, R7.6 billion) from the World Bank Group to enhance the procurement of 47 million vaccine doses, support the health system, and economic recovery.

17 Government Communication and Information System. (2021)
18 . Google News.(nd).
19 Google News. (nd).
20 Matema, T. & Kariuki, P. (2021).
21 UNICEF (2022)
22 Steyn, D. (2022).
23 South Africa Government. (2022).
24 Treasury (2022).

Impact of COVID-19 pandemic

Despite the gains in the vaccination space, South Africa remains one of the hardest hit countries by the pandemic.[25] Economically, socially, environmentally, and technologically, COVID-19 has had diverse implications for South African society. Closure of international borders, lockdown orders, and the current global economic recession has largely impacted poor people's socio-economic status, where the early stay-at-home orders prevented people from engaging in economic activities and earning income, especially those in the informal sectors[26], and these affects continue to be felt.

In terms of the health system, for decades, it has shouldered the burden of diseases such as HIV and TB, provided health services for family planning, under five child services, reproductive health services among others[27]. The treatment of these diseases has been challenging for the national and local health systems in general. However, the South African healthcare system has been overwhelmed[28] by the additional pressure added to the healthcare sector, with the effects of COVID-19 highlighting systemic weaknesses in existing health facilities in the country[29] in terms of stock outs, labor force weaknesses, child immunisation programme uptake, and the HIV response.

Stock Outs: Before the pandemic, many developing countries, including South Africa, faced a paucity of healthcare professionals. The shortage of professional healthcare workers became more critical with COVID-19, exacerbating pre-existing problems further, including stock outs, where there was a shortage of Personal Protective Equipment (PPE) such as gloves, nose masks, face shields, aprons, N95 respirators for frontline workers and healthcare professionals, putting them at high risk of infections and deaths. Shortage of equipment in facilities meant individuals were more susceptible to the virus.[30]

Labour Force: The pandemic had a profound effect on the labour force, influencing the available labour demand and supply. Prior to the pandemic, South Africa, unlike other developing middle-income countries suffered low levels of employment and job creation. However, the COVID-19 pandemic brought about increased levels of unemployment. According to a 2021 World Bank Report, it increased job losses whereby the initial level 5 lockdown in March 2020, resulted in job losses among young people, women, Africans, and low wage earners. The failure of the job market was prevalent among young people between the ages of 15-34, where it was estimated that, after the pandemic, about 63% of young people between 15-24 were unemployed while 41% between 25-34 were also without jobs. In addition, low wage earners were disproportionally affected being four times more likely to lose their jobs in comparison to high earners. This only widens the inequality gaps among communities, especially in a country like South Africa where inequality is a huge issue – this in turn affects health access and vaccine uptake where people do not have the means (financial or time) to travel to a clinic for a vaccine at the expense of work opportunities.[31]

25 Galal, S. (2022).
26 Sekyere, E, Bohler-Muller, N, Hongoro, C & Makoae, M. (2020).
27 Nyasulu, J., & Pandya, H. (2020).
28 Mbunge E. (2020).
29 Sekyere, E, Bohler-Muller, N, Hongoro, C & Makoae, M. (2020).
30 Mbunge E. (2020).
31 Hlayisi V. G. (2022).

HIV Response. Despite containing 0.6% of the world's population, the country accounts for 20% of the global population of those living with HIV. The country's investment in HIV epidemics gave it an advantage in its swift response to the pandemic, however, the pandemic then impacted the response to HIV[32]. Years of research and work put into the treatment of diseases such as HIV was put on hold through the temporary suspension of research, diversion of resources from HIV patients, and the reduced access of patient to health facilities. The impact of COVID-19 on HIV and other deadly diseases like TB has been a result of challenges, both in health facilities and the patient community. Data from the Global Fund indicates that, during the pandemic, HIV patients could no longer make regular visits to the hospital or were afraid to make those visits in fear of contracting COVID-19. The mandate to stay-at-home and disruptions in transportation also prevented them from going for medical care. In other cases, health facilities stopped or reduced standard medical services for HIV treatments due to the increase in COVID-19 cases, hampering patient access to medical care and causing declines in testing and monitoring of HIV cases. The shift of attention led to many people living with HIV not being tested or treated, increasing the possibility of people spreading the virus unknowingly[33].

Child Immunisation. The pandemic threatened routine child immunization programmes, with the WHO stating in 2021 that disruptions in health facilities and stable community life during the pandemic that caused a halt in routine immunisations has increased the risk of disease development in children, such as polio, measles, and diphtheria. Already, during the pre-COVID-19 era, child immunisations were not up to standard and now immunization coverage, especially in the African region. For example, there has been a decline in the coverage of the third dose of diphtheria–tetanus–pertussis vaccine, moving from a 90% coverage in 2018, to 74% in 2020. In 2015, it was also reported that the Ebola pandemic in Guinea had led to multiple measles epidemics among children due to a halt in routine immunisation. This is now occurring in South Africa; it is therefore imperative that routine child immunisations are sustained to prevent child morbidity and mortality from vaccine preventable diseases.[34]

Key barriers and enablers to COVID-19 vaccines, test and treatment supply, distribution, and access

Barriers

When COVID-19 vaccines became available for use by countries, it brought a sense of renewed hope for many who had been devasted by the illness, its ongoing effects, and the high death rate in the early months of the pandemic. The development of safe, efficient COVID-19 vaccines symbolised a solution to national and global struggles at the start of the pandemic. However, just as rollout and acquisition of vaccines began, tensions arose related to its safety, accessibility, equitable distribution, and supply related challenges. In Harry Gwala, a district in KwaZulu-Natal, there is decreased acceptance and concerns over the safety of the vaccine. According to residents in this settlement, people will start dying after two years of taking jab[35]. In Bojanala and rural KZN settlement, access to vaccines is limited. Many people in these settlements, do not have transport to vaccination sites, raising issues of equity in access to vaccination sites. In addition, it was reported that in those settlements, there was strong preference for Pfizer vaccines, which were only in stock for few days in a

32 Karim, A, Q and Baxter, C. (2022).

33 Holtz, L. (2021).

34 Adamu, A. A., Jalo, R. I., Habonimana, D., & Wiysonge, C. S. (2020).

35 Vaccines for Africa. (9 Feb 2022)

week[36].

Vaccine hesitancy: It is very important to note that, vaccines are a crucial step in the fight towards personal health, protecting vulnerable population, opening borders and economies, and ensuring herd immunity. The success of COVID-19 vaccines relies on the high uptake by individuals. However, there have been several reports that shows questioning, delays, and refusals of individuals in getting vaccinated globally and nationally.

South Africa began its vaccine rollout in February 2021, with the distribution of Johnson and Johnson (single dose) and Pfizer vaccines (two dose). The aim of vaccinations was to ensure that about 70% of the population was vaccinated to gain herd immunity. However, by June 2021, only about 1.1 million South Africans had received at least one dose of the vaccine. There are many reasons why South Africans are hesitant to accept the vaccination and thus, have negative attitudes towards it. For most people, vaccine hesitancy comes from beliefs, experiences, culture, personal backgrounds, politics, and social conditions, among other factors. It involves many levels of mistrust, doubts, indecision, uncertainty about the effectiveness, safety, efficacy of vaccines. Age, race, geographical location, education also play a role in understanding vaccination views. In South Africa, it was found that young people are less accepting of vaccines than older people. Non-black South Africans, those living in rural areas, and those that were highly education were found to be doubtful of vaccinations.

Analysing a series of surveys conducted by different groups in South Africa, Cooper, Rooyen and Wiysonge[37] found that South Africans were hesitant in taking the vaccines due to the issue of trust in the Government. Trust plays a key role where those that have positive attitudes towards the Government and are content with how the COVID-19 crisis was managed were more willing to take the vaccine. Those that were discontent and disillusioned or had suspicious feelings towards the Government based on past or present actions or experiences showed distrust in the whole campaign for vaccinations. Thus, trust played a major role when it came to acceptance of vaccine. Additionally, during the pandemic, some South African authorities were flagged for ongoing corruption and fraud in COVID-19 contracts, with 386 people referred to the National Prosecuting Authority and 330 companies blacklisted[38] demonstrating to young people especially a lack of transparency and thus resulting in resistance and hesitance to vaccinate.

Other reasons for hesitancy include a concern that the vaccines could result in serious medical concerns. Worries about safety constituted the reason that a third of South Africans are hesitant in taking the jab. Others claim that the vaccine is too new and therefore wanted to wait to see the side effects on others before they agreed to vaccination.[39] To them, because it was developed so rapidly, it cannot be trusted.

Finally fake news, myths, and misinformation about vaccinations contribute to hesitancy. In South Africa, there has been common misinformation being peddled around communities. For example, in Namakwa, Northern Cape, misinformation was a significant source of hesitancy, including stories that undocumented persons will be arrested and repatriated when they go for vaccination, or that one can stop wearing a mask after vaccination, or that vaccines cause infertility and erectile dysfunction in young people[40]. People speculated that vaccines are only needed by older people because they are most at risk of death and other health challenges. Others spread false news that

36 Department of Health (2022).

37 Cooper. S, Rooyen. H, & Wiysonge, C.S. (2021).

38 Engelbrecht, M.; Heunis, C.; Kigozi, G. (2022).

39 Cooper, S, Rooyen, V.H, Wiysonge, C.S. (2021).

40 Nair, K. (2021).

the vaccines contain a microchip that tracks and shuts one down when they misbehave.[41] This raised fear and doubts among people. Additionally, Burger et. al[42] informs that people who trusted social media as a source of COVID-19 information were more likely to the hesitant to vaccinations.

Vaccine access: Equitable access to safe and efficient vaccines is key to ensure that no one gets left behind in the global fight against COVID-19. While vaccination rates have been growing steadily around the world, data reveals that vaccination rates in the African continent are lower than its neighboring regions. As of June 2021, among the 1.5 billion vaccines doses administered around the world, fewer than 25 million doses have been administered on the African continent, a continent with a population of 1.6 billion people. 75% of vaccine supply have gone to 10 countries. While wealthy countries are competing to buy sufficient stocks to vaccinate their entire population multiple times over, many of the poorest countries are unable to procure enough vaccines to protect even their health workers. In high-income countries, children are being vaccinated, despite little likelihood of significant morbidity or mortality, while millions of vulnerable, often older, individuals in low-income countries are getting sick and struggling to find basic elements of care such as oxygen and hospital beds[43].

Vaccine equity and access is therefore a challenge that is yet to be achieved. In South Africa there remains a sufficient availability to vaccines, but there are challenges in ensuring access to those that want them. Vaccine access has been a major contributor to non-vaccinations in South Africa.[44] In provinces such as Free State, especially Bloemfontein, Lejweleputswa, when it comes to vaccination, there is a heavy demand and a short supply of the vaccine. People travel long distances from Bloemfontein to Welkom, spend money on transportation only to be sent back home because vaccines finished on the day[45].

Ability to acccess vaccination sites have also been a challenge in vaccine access. In Eastern Cape, it is reported that the lack of transportation to vaccination sites have made vaccinations inaccessible to people who cannot afford[46]. The lack of trucks and vehicles to get to vaccination have slowed down the vaccination uptake in rural areas in South Africa. With the emergence of new variants that are threatening human life, it is important that access to vaccines are enabled to secure economic and social life.

In addition, the lack of access to vaccines have come about because of the lack of capacity in African countries to manufacture large quantities of vaccines on the continent. Most of the African countries rely on donations and external support from international organisations like UNICEF and GAVI to receive vaccines in others to vaccinate their population. And these agencies will usually provide only limited supplies since vaccines are already scarce because pharmaceutical companies prioritise the needs of richer countries, leaving poor, underdeveloped countries to suffer and vaccination programs delayed. Unavailability and lack of access thus serve as a barrier to vaccination uptake.

Supply chain blockages: This encompasses the lack of existing pathways for vaccine delivery and logistical supply chain challenges[47] Supply chain blockages has been a barrier in vaccinations in South Africa where the Government had to destroy 100,000 Pfizer doses because the vaccines were going

41 SAMRC. (2021).
42 Burger, R., Köhler, T., Golos, A.M. *et al.* (2022).
43 Torreele, E., & Amon, J. J. (2021).
44 Vaccines for Africa. (21 Mar 2022).
45 Mochoari, R (2021).
46 Irvine, J. (2021)
47 Tomlinson, C (2020).

to expire at the end of March 2022. In September 2022, reports indicated that about over 8 million doses of Pfizer Covid-19 vaccines were going to be destroyed at the end of October due to expiration[48]. The limited shelf life due to the delay in reaching South Africa meant that were not suitable for intake. The unavailability of reliable ultra-cold supply chains has been a major challenge for most developing countries because most of these vaccines must be stored at a particular temperature and be consumed in a safe, legal, recommended temperature.

In South Africa there have been issues with storage, where, according to a news article for the Bhekisisa Centre for Health Journalism on the expiration of vaccines, "Pfizer vaccines have shorter shelf lives and more complex storage conditions. When stored at –70°C (in special freezers), the jabs last for 12 months. Very few vaccination sites have freezers that can keep shots at –70°C, so sites mostly keep them at –20°C (this can be done in normal freezers), but jabs can only be kept frozen at this temperature for two weeks. Once the vials in which the vaccines are kept (there are six doses in each Pfizer vial) have been thawed, they must be used within 31 days"[49]. This means that having enough cold chain supplies is important to get vaccines safe for use.

Distribution challenges to hard-to-reach communities remains a challenge in vaccine supply. Some communities are in very inaccessible locations making it hard for healthcare professionals to reach them with enough supplies[50]. Further, the lack of pharmacists and health officials to sign off supplies from airport and to attend to patients has been a barrier in vaccine supply[51].

Enablers

Technological innovation: COVID-19 has taught us that expanding local and regional production is a sure way to enhance heath systems in low- and middle-income countries. The creation of local ecosystems of vaccine production will seek to help poor countries in battling impacts of COVID-19, as well as to equip them with more reliable and more equitable supply in the next crisis.

The WHO is supporting efforts to create and spread mRNA technology in developing countries. In mid-February 2022, the WHO chief announced that six African countries would get technology transfers to locally produce mRNA vaccines. This is to allow for the spread of technology to developing countries by training and licensing manufacturers to produce their own vaccines for regional and local use. In South Africa, local billionaire Patrick Soon-Shiong opened a new vaccine manufacturing plant in Cape Town in mid-January. This should boost Africa's access to COVID-19 vaccines by increasing supply locally, thus reducing vaccine transport costs incurred in procurement and ending the trend of vaccine dumping[52].

Through technology, South African scientists discovered the Omicron variant. The Omicron was first reported to the WHO on 24 November 2021 and, two days later, was declared a "Variant of Concern"[53]. It was first discovered in South Africa in a Lancet laboratory sequencing COVID-19 samples, and the world was immediately made aware of its existence to ensure adequate preparedness[54]. However, instead of being praised for its due diligence, the world punished South Africa and the rest of Southern Africa. Unfair travel restrictions were imposed, effectively closing off Southern Africa, and the Omicron variant was dubbed an 'African' variant, despite also being

48 Ismail, H. (2022).
49 Kunene, Z. (2022).
50 Irvine, J. (2021).
51 Moffat, C. (2021).
52 Roelf, W. (2022).
53 WHO (26 November 2021).
54 Cocks, T. (30 November 2021).

found in Europe[55].

Technological/ digital innovation has been utilised by South Africa in the form of its Electronic Vaccination Data System (EVDS) which ensures effective and efficient monitoring of vaccine roll-out programme. With a campaign for vaccination implemented in South Africa, EVDS has been developed to track and monitor vaccine information, the type of vaccine administered and batch number, the individual's demographics, safety information (including those that have possible adverse reaction to the vaccine) after vaccination. This is to ensure that vaccines are administered efficiently and also that people are safe[56].

The National Department of Health, through support from Right to Care, established vaccination programmes in Eastern Cape, Free State, Northern Cape, and Mpumalanga. Through experience with HIV care and disease treatment, Right to Care is rolling out a comprehensive, upscale treatment in South Africa in rural areas. Through the use of mobile teams and pharmacies, the goal is to ensure that all miles are covered in pursuit of herd immunity. Through this digital initiative, about 43,000 frontlines workers have been vaccinated. Right to Care stated that, "We use sophisticated GIS geographic information system (GIS) technology to assess routes and plan the transportation of the vaccines from central to peripheral distribution sites. Our pharmacy teams use these maps to establish the best place to store and distribute the vaccines"[57]

Multi-sectoral collaboration: During September, Minister of Higher Education, Science and Innovation, Dr Blade Nzimande, told reporters that "current operations of Biovac, a company established in 2003 as a public-private partnership to produce local vaccines in South Africa, would be expanded. The upscaling of Biovac's manufacturing capabilities is important to ensure that COVID-19 vaccines can be manufactured for African use by an African company". "The upscaling of the manufacturing pipeline for hundreds of millions, or even billions, of doses will require intense collaboration and needs to be done in such a way that it will not compromise the production of other essential vaccines"[58].

Other examples include the donation of 2197 cold-chain units in South Africa by the Vodacom Group.[59] Through joint campaigns with CSOs and the private sector, the Government has prioritised vaccinations across the country through strategies like the Youth led KeReady Campaign, where young medical doctors explain the safety and efficacy of vaccines to dispel myths and hesitancy, anxiety, and stigma associated with vaccination intake[60].

The Government has also joined a partnership with the United States (US) Government to campaign for global COVID-19 vaccinations under the Global Vax Campaign[61]. This was a joint initiative by the US Government to ensure that 70% of the world's population is vaccinated against the virus.

In local townships like Ivory Park, there has been local initiatives like Zwakala, led by the United Nations International Children's Emergency Fund (UNICEF), United Nations (UN), the Department of Health, Community Groups to enhance vaccination intake among the youths[62]. This campaign relies on community-to-community engagement to educate and communicate the safety intake of vaccines among the youths.

55 BBC News (28 November 2021).
56 Dugbazah, J, Glover, B, Mbuli, B & Kungade, C. (2021).
57 Right to Care. (2021).
58 Government of South Africa (2020).
59 Health Department (2022).
60 South African Government (17 February 2022)
61 South Africa Government. (2022).
62 Paul, D.J. (2022).

Community Engagement: To support vaccine uptake in South Africa, teams of trained Zwakala community mobilisers are going door-to-door to bring vaccines to where people are, making it easy to get vaccinated while mobilisers are on site to share the facts about vaccination, respond to myths and assist young people to make informed decisions about their health and the health of those around them[63].

Another community engagement initiative undertaken during the covid-19 vaccinations in South Africa was the Sisonke trial (translated as We are Together in isiXhosa). The Sisonke Trial was started by the South African Government to understand the effectiveness of vaccines and its boost against covid infections. The vaccine trial began because the ChAdOX1 nCoV-19 vaccine, procured by the South African government could not protect against the beta variant. A single dose of Ad26.COV2.S vaccine however, proved to be effective against the beta vaccine. To help researchers better understand the vaccine, volunteer healthcare workers, came together to take the single dose vaccine. This trial yielded positive result by providing important, real-life data on vaccine effectiveness and through that enabled South Africa to start vaccinating important risk groups[64].

The 'Vooma Vaccination Weekend' was a community engagement programme by the Government to encourage vaccinations across the country. The aim was thus to vaccinate half a million people over the weekend of 01 to 03 October 2021, and a further 16 million people by the end of the year. The motive was also to dispel false information and to ensure that all people have access to vaccinations.

Implications for programming

Risk assessment

The implementation of the P2A programme brings a number of risks, which can broadly be categorised as: contextual; programmatic; organisational; and technology and data related. It is important to consider the context in South Africa, and sample of identified barriers and enablers to COVID-19 vaccines, test and treatment supply, distribution, and access when assessing risk, while also recognising that risk management is not a once-off activity as part of the initial baseline, but an ongoing function of programme management. As such, it must be integrated into our approach to MEL and reporting from a programmatic perspective, as well as monitored actively regularly through programme activities themselves, generating real-time information about the environments the P2A implementing partners and monitors will be working in. Our approach considers the risk to partners, monitors, and community members, among others, and includes the need for collaboration at different levels to effectively monitor and mitigate risks as they emerge. Tools, policies and guidelines will be developed as needed to support our risk management approach.

Contextual risks

Many countries on the continent are dealing with **political and/or economic fragility and are susceptible to internal and external shocks** (natural disasters, climate change, pandemics, conflict, etc), and South Africa is no different, with rising unemployment – particularly for young people, internal conflicts of GBV, and the emerging recession with rising interest rates and costs of livings affecting those most vulnerable even further. The COVID-19 pandemic continues to add to this fragility, particularly in terms of creating pressure for health and economic systems.

Civil society also faces the challenge **of restricted civic space**, impacting their ability to influence or hold duty bearers (State authorities) to account, as described earlier. The majority of African

63 UNICEF. (2021).

64 Preiser, W & Fish, T. (2022).

states are classified by the CIVICUS Monitor[65] as 'repressed', with some, including South Africa described as 'obstructed'. Consequently, the work of local organisations and groups, particularly those working with groups whose identities may be criminalised or repressed under morality legislation in these spaces (e.g., sex workers and LGBTIQA+ people) are under constant scrutiny of state, political and societal actors.

The Alliance will engage closely with local partner organisations to jointly analyse these risks, beginning with this initial baseline setting activity which sought to map out current contextual realities, challenges and opportunities in relation to the P2A project, and identifying particular risks, for example, despite the Constitution recognising LGBTIQA+ people and their organisations, in practice, they continue to be structurally excluded, discriminated against, harassed and detained for being who they are, impacting their ability access health services and commodities.

Actions emerging from the evidence-based advocacy strategies may lead to opposition, but it is hoped that the proposed approaches and strategies (e.g., using locally-based monitors embedded in their communities and well-networked into the health rights sector, and using locally collected and analysed data) will mitigate these risks and generate a strong support base for any actions to counterbalance potential opposition. Moreover, narratives will be carefully chosen and contextualised to ensure advocacy messaging is localised and relevant, and not seen to have 'global north' influences.

Country-specific safety and security plans will be developed as the pilot rolls out for partners to adapt to their provincial contexts, and an advocacy response grant has been budgeted for as part of the larger P2A Africa project (funded by the Hilton Foundation and OSF Africa) for crisis support. This will include an accompanying emergency protocol, a contact list and an incident reporting document. In addition, any human rights violations that may be experienced as a result of engagement in the P2A project can be reported through Frontline AIDS' (an Alliance partner), Rights, Evidence, Action (REAct) reporting mechanism[66].

The **initial orientation and training** that all partners and their monitors will receive will also include sessions on safety and security, including psycho-social wellbeing, and they will receive resources to support this (participant manual and relevant handouts, and relevant protocols as described above).

In this way, P2A also creates strong safety and security capacities and knowledge, and by localising this approach, the response to any incidents will be faster and more context-appropriate by connecting to both the project network but also local emergency mechanisms.

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65 See the CIVICUS Monitor for specific country classifications: https://www.civicus.org/index.php/what-we-do/innovate/civicus-monitor

66 See: https://frontlineaids.org/our-work-includes/react/ - REAct currently operates in 19 African countries.

Programmatic risks

For P2A to be a success, it is critical that the **lead partners work well together**. Any breakdown in relationships can potentially have a significant impact on programme outcomes. The Alliance and McGill University have been working together for nearly two years on the P2A concept, and the team recognises, values and respects each other's expertise and contributions. There are well-developed communication protocols and interpersonal relationships in place, and sound and clear accountability mechanisms for the programme have been agreed on in the form of the Community Reference Group (CRG), which has been set up and will meet in early 2023. In addition, the different responsibilities and accountability have been clearly delineated in the work to date, and in the planned programme activities.

Partner organisations housing provincial community monitors play a pivotal role in the P2A programme, and therefore **careful recruitment, training and support of partners** will be key. Support will happen at multiple levels – through monthly check ins with the Alliance team; technical MEL support; technical support from McGill to interact with the Tracker itself; cross-country or regional learning events; attendance at global events; and other activities.

The COVID-19 pandemic may pose a risk to activities, though as of April 2022, South Africa ended its initial state of emergency, thus paving the way for face-to-face data collection activities (meetings, workshops etc with key stakeholders) and advocacy activities. However, ongoing waves of outbreaks of new variants are predicted and, as of January 2023, continue to be experienced, and it is expected that this will continue until vaccine equity can be achieved. This may inhibit some activities (e.g., travel to certain countries, meetings with groups of participants with higher health vulnerabilities, etc) but at the same time, after two years of the pandemic, there is greater literacy of digital technologies for communication purposes that may also mitigate this risk. Access to internet (mobile data) has been included in the P2A Africa budget for monitors to ensure they are able to fulfil their roles, and an emergency grant has also been factored in to contribute to the replacement of digital devices as needed (based on a set of pre-determined criteria).

Fraud or corruption would damage the reputation of the programme and partners. Both lead organisations have experience of grant making and tested systems in place to avoid this from happening. Our proximity to local realities will also allow for close monitoring and identification of potential problems, as well as whistle-blower procedures to facilitate the reporting of fraud or corruption early on.

Safeguarding against sexual exploitation, abuse and (sexual) harassment (SEAH) is critical. Our approach recognises that many key populations group members, especially those who engage in sex work, intersex or trans people and LBT women are more vulnerable to such abuse, multiplied by issues of poverty, literacy and access. To mitigate this, SEAH procedures and mechanisms will be put in place, and form part of the training and contracts with all sub-grantees. Strong whistle-blower and response mechanisms will be in place, with potential incidents and follow-up actions part of the CRG's agenda.

Organisational risks

At the personal and interpersonal levels, when working on issues that people are passionate about, significant amounts of energy are directed into the work. Given the potential scope of the programme, and the contexts worked in, this may lead to disappointment and burn-out, which not only impacts the programme, team and organisation but the individual. Supportive check in mechanisms is already in place and will be expanded for the duration of the programme to monitor teams at different levels for signs of burnout, take action and provide support. Ensuring adequate resourcing will be key to not overburden our current and future teams and partners.

P2A is being implemented in some provinces that may, at times, have high safety and security risks, and a high incidence of violence, exacerbated by the sensitivity of the topic of COVID-19 vaccines specifically, and health access in general. Training of monitors will include how to take the necessary precautionary measures and, if a partner organisation, have sound safety and security procedures in place, including an emergency protocol. Other than that, each organisation will make sure to have a sound insurance policy. African Alliance is likely to experience financial risk when financial transactions are denominated in a currency other the domestic currency. However, this will be managed through using the weighted average exchange rate on reporting or modifying the budget without major effect on the implementation plans.

Technology and data

It is anticipated that the data collection interface, when it shifts from paper, will likely be via mobile phone, or, as a secondary option, computer. Increasingly there are risks of data leaks or hacking which can result in sensitive data falling into the wrong hands, leading to online and offline harassment, threats, violence or even arrests. The programme has a data management approach to safeguard sensitive data, and the back end of the Tracker is password protected. Data management and security will form a core component of the monitor training and form part of the programme's MEL function.

In summary, we see risk management as not a once-off activity, but an ongoing function of programme management, and as such, it is integrated into our approach to MEL and reporting from a programmatic perspective, as well as monitored actively on a weekly basis through programme activities themselves, generating real-time information about the environments the P2A monitors will be working in. Our approach considers the risk to partners, monitors, and community members, among others, and includes the need for collaboration at different levels to effectively monitor and mitigate risks as they emerge.

There are a number of risks related to implementing P2A, an initial set of which have been identified through this baseline and considered as much as possible at this pilot stage. Tools, policies and guidelines will be developed as needed to support our risk management approach, noting that Internal risks, such as SEAH, fraud, and a breakdown in relationship between partners are within the partnership's span of control. External risks, such as armed conflicts, natural disasters, and further shrinking of civic space, are beyond our control. What we can control however, is how we prepare for and react to these risks.

Therefore, we will further develop and implement already identified and agreed on overarching

measures to mitigate these risks, using our joint experience and expertise. In case an incident does occur, we will respond promptly and proportionally, thereby minimizing the impact on both personal and programmatic level.

Specific policies, procedures and mechanisms will be developed as part of programme inception, building on those of the Alliance and as part of the partnership agreements, how to best monitor risks, how and who to inform about these risks, how to take mitigating measures, and what procedures to follow if a crisis or incident occurs will be discussed. A simple framework to help partner organisations share and jointly discuss these risks will be drafted.

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