



## **SOUTH AFRICAN RESEARCH CHAIR IN SOCIAL CHANGE**

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### **UJ Social Change Vaccine Rollout Project**

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#### **1. Introduction**

This project is conceived as community action research. That is, research engaging directly with community activists who seek to solve problems. Given the urgency of the roll-out, it takes a rapid response form, providing speedy feedback on opinions and experiences. Findings are anecdotal, so *not generalisable*, as, for instance, with the UJ/HSRC Covid Democracy Survey. We look for ways to replicate action rather than *generalise findings*. Where problems cannot be solved on the ground they can be taken up in policy fora, and lessons are learnt from the whole process.

For the first the three weeks, the researcher has been based in Protea South, an informal settlement south of Johannesburg, where he is a community leader. We have been collaborating with the Community Organizing Working Group of the C19 People's Coalition. In the coming weeks he will move to other parts of the country, undertaking further community action research with assistance from local leaders.

We are grateful to the National Research Foundation, which administers the funding of the South African Research Chair in Social Change on behalf of the Department of Science and Technology. We are also indebted to the National Institute of Humanities and Social Sciences which supports this project through its Covid-19 Programme (specifically the Civil Society cluster).

#### **2. Field report from Protea South**

##### ***Hesitancy***

There is widespread hesitancy, with people complaining about lack of information from the government, and some turning vaccination into political jokes. Many people said they would

take the vaccine when they saw others doing so. The researcher met with a group of four sangomas, of whom three were opposed to vaccination and only one was in favour. They each had between five and 20 clients a day, so could be 'influencers' but also a potential vector for transmission. They did not understand 'waves' and were angry about their exclusion from education around the vaccine.

### ***Registration***

At a meeting with young people from the Soweto Sukuma Sinqobe Movement (SSSM) it was possible to answer questions and persuade some of the activists to assist older people to get vaccinated. The researcher met Community Health Workers (CHWs) who were going from door to door registering people with pencil and paper. A meeting for old people was held in a tent hired from the church and they were invited to the meeting using the church's megaphone. Thirty-seven old people attended and some of the CHWs also came. Questions were answered, and afterwards 20 registered; the other 17 having already done so.

Using pencil and paper to register is laborious and some people complained they had registered but had not received an acknowledgment on their phone. The system could be improved by using cheap smart phones to register people. Greater use could be made of unemployed youth, but most of them are hungry and need food.

### ***Vaccination***

The researcher drove three old people to Lenasia Clinic for vaccinations. One was a woman in her hundredth year. There was no checking for registrations or SMS invitations, only IDs were required. Even here, everything was done on paper. When the clinic ran out of vaccination cards, the researcher assisted by photocopying A4 vaccination 'papers'.

The two nurses vaccinating were very helpful and friendly, and the three Protea South residents were relieved and proud after their vaccinations. However, there was scope for improvement. More people could have been vaccinated if there were assistants to explain the need to come back in six weeks and take Panados (paracetamol) for any pain, but this had to be done by the vaccinators themselves. To deal with the workload, the vaccinators spoke to two patients at the same time, increasing the risk of misunderstanding. There were posters in the waiting area, but they were all in English. There were only a few seats, so people might have to stand for a long time in the hot sun, an unpleasant experience, especially for people who are frail.

After this, one of the 'gogos' who had been vaccinated phoned the researcher with a request to take another, larger group of people to Lenasia Clinic. This was interesting because she had previously been very sceptical but was now an 'ambassador'. Lifts were provided for the new group and some others, but this method of transport depending on one individual and their car is not sustainable. There needs to be an official plan for taking people to vaccination sites if they require a lift. It requires two taxis to get to the clinic, a cost of R22 there and R22 back. This is too much for most people in the settlement, so unless transport is provided many will be left unvaccinated, even though they want to be safe, and some will doubtless die as a consequence.

On the second day, the clinic had changed the system and there were two queues, one for people who had registered and one for people who had not. This created confusion because sometimes there would be a couple or a group who were split up, making transport even more of a problem.

Panados provided a talking point and were a source of complaint for people who had been vaccinated. Again, cost was an issue. For some people there was also a sense of injustice: the government had told them to get vaccinated so the government should provide the Panados.

### **Masks**

Only a small minority of people will be vaccinated prior to the peak of the third wave, and the majority will have to protect themselves and others by following well-established protocols and regulations. Before the President's most recent 'family talk' people had stopped wearing masks in the settlement – they did not wear them on the streets, in spazas or in taverns, and there was no use of sanitiser. So far, there is no indication that matters have changed. This is sad, because under Level 5 the SSSM ran a very successful campaign to persuade people to wear masks. The slogan 'Asivikelane' was developed ('I protect you, you protect me'). But people did not understand how the situation could be getting worse if the government had moved from Level 4 to Level 3 and then Level 2. Now some people say that Level 2 is not so much, because it is less than Level 3.

Some young people watch TV and are getting scared about the third wave, but most people do not watch TV and will not worry until they know people who die. Some others have difficulties obtaining masks, with a few sharing them or carefully washing cheap surgical ones.

### **3. Reflection**

In principle, the Electronic Vaccination Data System (EVDS) is a good idea. It should have reduced inequalities by vaccinating people in the order they registered. But inadequacies of the government's implementation undermined this. People with cars and petrol money can drive around vaccination sites until they find a relatively short queue for 'walk-ins'. This is not possible for poor people, who, as seen in this case study, do not have the funds to reach their nearest site, let alone go from one to another.

In addition, EVDS was introduced as a technocratic solution to a social problem. First, many people do not have the information they need to make an informed decision about vaccination. People with smartphones and computers read online posters in English. Those without such gadgets and linguistic competency need posters on walls and flyers in hands, preferably in their own language, and they need far more coverage on radio and TV. Secondly, even though it is free and relatively easy to register by phone, the steps are not adequately conveyed and, again, messaging has prioritised an online process. People without access to any kind of phone, and there are still many of them, must not be excluded from information and registration.

At least in this case, the CHWs were playing a valuable role in overcoming communication and registration problems. However, there were too few of them, they were poorly tooled, and they would benefit from employing a range of techniques. Perhaps the most important influence determining people's willingness to take the vaccine is knowing neighbours and friends who have already been vaccinated. This process is cumulative.

An increasing number of people want to take the vaccine. This is reflected in survey data and illustrated in this report. A minority of people are strongly opposed to vaccination, as in other countries, but this is not the immediate problem. According to the President there are already three million people on the EVDS system, and only about two million of them have been vaccinated. *We have a delivery problem not a demand problem.*

This 'delivery problem' is partly about *efficiency*. The EVDS has been chaotically administered, government communication has been chronically weak, and there are not enough vaccination sites and staff. However, it is mainly about *equity*. Old people most in need of shielding against the virus, those living in congested informal settlements where poverty is deep and rife, have greater problems in obtaining vaccination. Impoverishment and its implications for the roll-out is signalled in numerous ways, including prioritising hunger alleviation over health protection, complaints that R10 for Panados is a significant expense, volunteers requiring food, and lack of access to information and registration. The position facing the poor of Protea South is very different from that confronting the middle-classes in Africa's richest city. *Defeating the virus is not only about securing vaccines, it is also about combatting class division.*

#### **4. Recommendations**

*Our case study is situated in an informal settlement south of Johannesburg, where infections are rising especially rapidly, so our recommendations have urgency as well as, in our view, credibility. We propose the following:*

- Assist the CHWs by recruiting local youths who can help with education and registration; provide them all with smartphones and data; and draw on the mobilising skills of experienced community activists.
- People must be taken to the vaccines or vaccines must be taken to the people. Metros and local municipalities should second or recruit staff to co-ordinate transport for poorer people to reach vaccination sites. The transport could be taxis, volunteers' cars, private taxis or buses. In addition, there should be a move towards using mobile vaccination units.
- When people are vaccinated, they should be offered free Panados and free masks; and free masks should be available in clinics, schools and other public places.
- The government should provide emergency financial assistance in the form of improved pensions and restoration of the Social Relief of Distress grant.