

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

Chapter 2: Government leadership, governance, and institutional arrangements

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Chapter objective

Chapter 2 of the 1st Edition Covid-19 Country Report focused on leadership, governance and institutional arrangements in the first year (March 2020 to March 2021) of the Covid-19 pandemic. The pandemic tested the capacity of existing institutional arrangements and the Disaster Management Act and the Country Report identified limitations in the existing established institutionalised capacity for effective and accountable disaster management. While the legal framework and institutional coordination capacity were rapidly strengthened at the onset of the pandemic and played an important role in saving lives, the lasting effects of the pandemic on economic recovery and livelihoods were evident as the pandemic and lockdown arrangements continued.

Chapter 2 of the 2nd Edition Covid-19 Country Report documents how the second year of the pandemic and the interventions implemented by sectors in response. There will be a special focus on the vaccine rollout (including vaccine hesitancy) from a governance and leadership perspective, including a

reflection on the extent to which the vaccine rollout programme implemented by various sectors and spheres of government, considered vulnerable groups. The report will document learning experiences, successes, challenges and failures in implementing various interventions as the pandemic unfolded after the first year. This will be the basis to formulate lessons from the experience and recommendations for any future disasters, not limited to health-related conditions, but also to other events, such as climate change, energy, food or water supply crises.

Introduction

The second period of the pandemic (Feb 2021 to Dec 2021) continued to follow a risk-adjusted strategy to phase in specific response actions and implement the various regulations emanating from the State of Disaster. These measures were aimed primarily at reducing the rate and extent of Covid-19 infections, and encourage vaccinations. Better cooperation and coordination in disaster risk management (DRM) and response amongst sectors (horizontally and vertically) occurred. This period saw a heightened interest in DRM across all sectors at a national and provincial level, with the National Disaster Management Centre (NDMC) trying to inculcate a resilience-building focus in their actions and planning. This was, however, less effective since the NDMC were not the coordinating institution for the Covid-19 response.

As the pandemic unfolded in the second year, several government role-players became more familiar with the statutory and regulatory aspects of disaster risk reduction as espoused in the Disaster Management Act 57 of 2002 (as amended) (DMA) as well as the National Disaster Management Framework (NDMF). This was driven mainly by the continued national State of Disaster and several additional significant natural hazards affecting several provinces. Departments realised the value of adopting a more risk reduction focus in their respective pandemic management. However, there remains confusion as to how disaster risk reduction can and should be, incorporated into the day-to-day functioning of these sectors. Therefore, a disaster response focus still permeates most public sector perceptions and thinking of DRM. Sectors and departments were not applying an anticipatory governance perspective to possible other hazards and the entire risk profile of the country.

Thus, as seen below, the compounding effect of different hazards and complex emergencies further strained the resources and capacities of the public sector. An "all systems approach" to DRM is not present in the public sector. Systemic, complex, and multiple risks placed additional stress on an already stretched public sector, especially at the local government level. During this period, provinces played a central role in the coordination of the vaccine roll-out and the coordination of DRM and response activities. In general, there seemed to be good cooperation between the local and provincial spheres of Government, with evidence of inter-provincial linkages and learning.

Methodology

The scientifically driven situation analysis approach adopted in the 1st Edition Report was also be applied in the 2nd Edition. Where possible, primary data-gathering methods was be used, which will include virtual interviews with key stakeholders including Covid-19 established committees and structures, departments, social partners and community-based organisations and representatives that can provide the citizens' views. Secondary data in the form of desktop analysis, literature review of Covid-19 related local and international reports that can be synthesized and benchmarked with the South African experience was be utilised. Additional information on national and provincial effects of, and responses to, the pandemic, was elicited from a media scan, and from government and academic reports.

Capturing government interventions involved interviews with the senior managers (e.g. HODs, Chief Directors or the heads of risk management) across the sectors and spheres of government to capture the lessons learned in the successes and challenges of implementing the response¹. The DPME provided logistical and technical support to engage stakeholders and record the interviews.

Individual and group interviews were conducted via TEAMS between November 2011 and May 2022. A list of generic interview questions was shared before each interview with some customization to the sector. This allows for comparisons between sectoral responses as well as nuances specific to the sector. The interviews were recorded and the captured responses to each question were shared electronically after the interview with the respondents to verify the accuracy of the recorded responses.

The captured interview data was imported into ATLAS-ti and coded. For some of the interviews, a review of the information in the first level structured analysis informed a second-level analysis which covered narrower themes that emerged from the data. As the management of the pandemic and its social and economic repercussions is still ongoing, the findings here are still open to further empirical and non-empirical research.

Timeline after March 2021

The second period of the pandemic (after March 2021) saw a heightened interest in disaster risk management across all sectors at national and provincial levels. Various departments realised the value in adopting a more risk reduction focus in their respective management of the pandemic. However, it became clear that there is still significant confusion as to how disaster risk reduction can, and should be, incorporated into the normal functioning of these sectors. Most surveyed departments were not aware of their legislated and implementation role under the DMA and NDMF and after the termination of the DM regulations. Although the NDMF requires each organ of state to identify a disaster risk management focal point, this has mostly not been undertaken because these departments and entities were not aware of this requirement. There was general agreement that should these focal points and disaster risk management structures have been in place (prior to 2020), the management of the

pandemic would have been much more effective and that further actions may be needed in the wake of the pandemic to provide for stronger institutions to respond to future pandemics. Emphasis was placed on the location of the disaster risk management function within Government. Most respondents felt that the NDMC must be placed under the highest political authority (i.e. in the Office of the Presidency) – which will facilitate similar placing within the other spheres of Government (e.g. provincial and municipal level).

In the second wave the implementation lines between disaster risk management and humanitarian response became blurred. There remained the need to address the continued medical response to the pandemic but also the vulnerability created by this response. The impact on the economy and well-being were brought into focus. The dichotomy of saving lives and saving livelihoods under the State of Disaster, and subsequent regulations, were stark. Emphasis in the second/third wave were more focussed on humanitarian actions, addressing social behaviour, economic recovery, and improving vaccinations.

Learning from first wave in terms of disaster response contributed greatly to better disaster risk management in 2nd and 3rd wave. However, “unseen” vulnerable groups in all provinces needed more and better attention to address their particular needs. To this end it became clear that government lacks a “whole of system” approach and understanding. The use of data improved (especially as reported by the Western Cape province) but integrated systems would have added more value to the humanitarian response.

South Africa entered April 2021 on Alert Level One, with all Provinces except for the Northern Cape in a post-wave status. Infection rates remained stable through April, except for the Free State and North West where there were modest increases. There were concerns, however, that complacency (‘Covid fatigue’), and the onset of winter with indoor gatherings in poorly ventilated spaces, would lead to a new wave of infections.¹

¹<https://www.unicef.org/media/97526/file/South%20Africa%20COVID-19%20SitRep%20no.15.%2030%20April%202021.pdf>; Madhi, S. and J, Myers (2021) Covid-19 resurgence in Gauteng: A crisis that is likely to worsen rapidly, published on Wits Covid-19 News, 22 June. Online at <https://www.wits.ac.za/covid19/covid19-news/latest/covid-19-resurgence-in-gauteng-a-crisis-that-is-likely-to-worsen-rapidly.html>



Graph 2.1: Timeline April 2021 – August 2022

April 2021: The quiet before the storm	• 2-5 April – Alcohol sales banned over the Easter Weekend • 13 April – SA temporarily halts the rollout of the Johnson & Johnson (J&J) vaccination after the USA suspends its use because of rare blood clotting cases • 14 April – The national State of Disaster was extended for a month (a process continued through the year). • 16 April – Online registration for vaccinations opened through the Electronic Vaccination Data (EVDS) system. • 17 April – Gauteng's preparation for the next wave is compromised due to a fire at the 1 000-bed Charlotte Maxeke Johannesburg Academic Hospital. • 23 April - The South African Health Products Regulatory Authority (SAHPRA) lifts the suspension of J&J • 30 April - The Covid-19 Social Relief of Distress Grant ends
May 2021: The mass vaccination drive begins and the Delta variant arrives in SA	• 4 May – A call for citizens above 60 years to register on EVDS; the first batch of Pfizer vaccines arrive in SA • 7 May – The government reports a concerning trend of increased infections in some districts • 8 May – Local cases of the Delta variant detected in SA • 13 May – Vaccination of individuals over 60 years begins • 14 May - Gauteng Premier, David Makhura, has announced that the third wave of COVID-19 has hit the province. • 19 May - The national department of education cancels all contact sports following Covid outbreaks in schools in Gauteng • 21 May – Some schools close in the Free State • 30 May – President Ramaphosa addresses the nation, expressing his concern at the rising infection rates • 31 May – SA moves to Alert Level Two • ENCA, 14 May 2021
June 2021 – South Africa enters the Third Wave	• 10 June - SA officially entered the Third Wave when it recorded 9 149 new COVID-19 cases and a 15.7% positivity testing rate. • 16 June – SA moves to Adjusted Alert Level Three • 23 June – Individuals over 50 years are permitted to register on the EVDS and the vaccination programme for educators begins • 25 June – The EFF marches against SAPRHA • 28 June – SA moves to Adjusted Alert Level Four (with restrictions on alcohol sales, an extended curfew, and restrictions on numbers at gatherings)
July 2021 – A Winter of Discontent as the Third Wave Peaks and Civil Unrest spreads in parts of the Country	• 3 July – SAHPRA authorises the CoronaVac vaccine • 9 July – Doctors in Gauteng describe the Covid crisis as 'beyond the breaking point' • 9-18 July – Civil unrest across KwaZulu-Natal and Gauteng creates a compound crisis for the country • 11 July – President Ramaphosa announces that Alert Level Four is maintained but with adjustments including school closures and restrictions on travel to and from Gauteng • 15 July - Registration of 35+ age group on the EVDS; President Cyril Ramaphosa • announces that the R350 Covid-19 Social Relief of Distress (SRD) Grant will be reinstated until March 2022. • 26 July – SA moves to Adjusted Alert Level Three



August 2021: The Third Wave Eases but with Regional Lags

- 20 August – Vaccines become available for people aged 18-34
- 23 August - Babita Deokaran, a key witness in exposing a corruption syndicate in the Gauteng Department of Health, assassinated.
- 31 August – 11 million vaccine doses administered to date (19% of the target population)

September 2021: The End of the Third Wave

- 13 September – South Africa moves to Adjusted Alert Level Two
- 26 September – The NICD reports that South Africa has officially exited the 3rd Wave

October 2021: Back to Level One

- 1 October – South Africa moves to Alert Level One but the mask mandate remains and government indicates that it is considering vaccination mandates.
- 19 October – Vaccinations open to the 12 – 17 age group
- 31 October – 51% of the target population vaccinated with 22.4 million vaccine doses administered to date.

November 2021: The Omicron Shock

- 9 November – A technician in the Lancet Laboratory in Pretoria discovers that testing for Covid did not detect the S-gene indicating a possible mutation
- 11 November - Four individuals leaving Botswana, and a man returning to Hong Kong from SA, test positive for Covid with genome sequencing later confirming Omicron
- 19 November – Lancet informs the Network for Genomic Surveillance (a consortium of testing labs) of a possible variant, and sends raw data to the NICD
- 22 November – The NICD determines that there is a new variant of the virus, initially referred to as B.1.1.529, with large numbers of mutations.
- 24 November – The NICD formally reports its findings to the WHO and Covid infections in South Africa increase; there are initial reports in the global media of a possible new variant.
- 26 November – The WHO classifies B.1.1.529 as ‘a variant of concern’ and labels it as Omicron; South Africa is added to the UK’s ‘red list’ with the SA government calling on the UK to ‘reverse the rushed decision’
- 28 November – Countries across the world place travel restrictions, including flight bans on SA; the WHO commends the SA and Botswana governments for their rapid action in sharing public health information and criticises the flight bans for threatening ‘global solidarity’; President Ramaphosa indicates that he is ‘deeply disappointed’ by the bans.

December 2021: The Fourth Wave passes through SA

- 12 December – President Ramaphosa tests positive for Covid
- 14 December – Preliminary assessment of health data indicates that Omicron is a milder form of Covid than previous variants with far lower hospitalisation and death rates.
- 15 December – South Africa is removed from the UKs ‘red list’ (meaning that travellers from SA will not have to stay in a managed quarantine hotel on arrival)
- 16 December – The NCCC announces that South Africa will remain on Alert Level 1 despite the Fourth Wave
- 17 December – SA reaches the highest number of reported cases per day
- 20 December – Reports suggest that the Fourth Wave has peaked and that SA is over the curve
- 30 December – The night curfew is lifted



January 2022: SA exits the Fourth Wave	12 January – The Department of Health indicates that only 275 of the SA population has been fully vaccinated 14 January – Gauteng officially exits the Fourth Wave 21 January – National Treasury announces that the World Bank has approved a R11.3 billion loan to SA after ‘difficult negotiations’ to help with Covid response. 31 January – Cabinet approved changes to Covid regulations including reduction in isolation period and dropping the requirement for Covid positive individuals (and contacts) to isolate if they do not have symptoms
February 2022: The Ebbing Wave	4 February – An announcement that SA scientists had replicated the Moderna RNA vaccine 7 February – Full-time schooling resumes 10 February – The President announces the extension of the Covid grant for another year 23 February – A study is released which indicates that 85% of Gauteng’s population had Covid before the Fourth Wave with other studies indicating that Covid deaths may have been three times the official figure 31 January – South Africa exits the Fourth Wave
March 2022: Beyond the Fourth Wave	4 March – Low demand for vaccination remains a concern with health officials indicating that 100 000 doses of Pfizer may have to be destroyed due to expiry 15 March – New draft Covid regulations released for public comment 22 March – A sharp criticism of the draft regulations by academics who argue that the regulations are unrealistic and oblivious to the new realities of Covid 23 March – A softening of restrictive measures, including the removal of all restrictions on economic activation, and the ending of the requirement to wear masks outdoors
April 2022: The lifting of the national state of disaster	4 April -President Ramaphosa announces the lifting of the COVID-19 national state of disaster with transitional measures, such as the wearing of face masks in indoor public spaces, remaining in place for 30 days 5 April – National State of Disaster lifted 11-13 April – Severe flooding in KwaZulu-Natal with more than 300 deaths compounds the legacy effects of the Covid-19 crisis 23 April – Covid infections begin to rise raising the prospect of a 5th wave driven by the BA.4 and BA.5 Omicron sub-variants
May 2022 – A fifth wave?	4 May – The transitional measures announced on 4 April expire but the government gazetted a set of new regulations under the Public Health Act, 2003 due to fears of an impending 5th wave 11 May – a minor wave of infection peaks but low levels of hospitalisation and death - See https://www.gov.za/sites/default/files/gcis_document/202205/46319gon2060.pdf
June 2022 – The regulatory regime ends	7 June – the ‘fifth wave’ effectively over 13 June - The World Bank Group approves a R7.6 billion loan for South Africa’s Covid-19 Emergency Response Project 13 June - Over 36.4 million vaccine doses have been administered, with about 50.3% of adults and 29.9% of 12 to 17-year-olds vaccinated 22 June – The regulations introduced on 4 May are withdrawn – including all mask, gathering, and travel mandates 23 June – The Minister of Health confirms the first case of monkey pox in South Africa
July 2022 – daily reporting ends	19 July - Health Minister Phaahla tests positive for COVID-19 31 July – The Department of Health announces the end of its daily reporting on Covid-19
August 2022 -readjusting social relief measures	16 August – Government gazettes a change to the Social Relief of Distress Grant (SRD) raising the income threshold for the means test from R350 to the food poverty line of R624 per month (but the grant remains at R350 per month)

The Third Wave (Delta)

The Delta variant which was first detected in India in October was identified in SA on 8 May 2021. It was soon to become the dominant strain in SA, displacing the Beta variant, and driving a third wave of infections. Gauteng was the first province to be hit, with local outbreaks in early May², and the Premier announcing on 14 May that Gauteng was in the grip of a Third Wave. Gauteng entered the Wave compromised by the closure due to a fire of the Charlotte Maxeke Johannesburg Academic Hospital, the health facility in the province, with the largest Covid-19 unit. Beyond Gauteng, North West, Free State, and the Northern Cape were early leaders in the Third Wave. South Africa officially entered the Third Wave on 10 June.³

With the arrival and progress of the Third Wave, the Alert Levels were raised – to Level Two on 31 May, Level Three on 16 June, and Level Four on 28 June. The major restrictions at the peak included: the prohibition of all gatherings, a night curfew, the prohibition on the sale of alcohol, school closures, restrictions on inter-provincial travel to and from Gauteng, and the mandatory wearing of masks.⁴ On 11 July there was some adjustment to the regulations with small gatherings permitted, and some venues, including restaurants and gyms allowed to open under strict conditions. In making the announcement President Ramaphosa claimed that ‘since the onset of the pandemic, our national response has been guided by the latest available evidence and the advice of experts’.

On 26 July South Africa was moved down to Alert Level Three indicating an official view that the peak of the Third Wave had passed. However, the Third Wave did not pass as quickly as the previous two, moving erratically across the provinces and so Level Three was sustained until 12 September 2021, after which there was a reduction to Level Two on 13 September, and Level One on 1 October.

The civil unrest during the second and third weeks of July involved the loss of more than 300 lives, and the widespread looting of shops, warehouses, and factories. There was damage to critical infrastructure, and a disruption to the national economy. The crisis affected the rollout of the vaccination programme in KwaZulu-Natal and parts of Gauteng, but fears of a major surge in infections in KwaZulu-Natal did not materialise.

² The outbreaks were in Sedibeng in the south of the province, in parts of Tshwane, and in individual schools.

³ The [Ministerial Advisory Committee](#) defined the threshold for entering a new wave as 30% of the peak incidence of the previous wave. See Zali, M., Gwala, N. and N. Mukwevho (2021) COVID-19 third wave: How ready is the infection epicentre Gauteng? 18 June, *Health E-News*. <https://health-e.org.za/2021/06/18/covid-19-third-wave-how-ready-is-the-infection-epicentre-gauteng/>

⁴ Government Gazette, No. 44838, 11 July 2021. Online at <http://www.energy.gov.za/files/docs/44838CoopGov.pdf>

The Vaccination Rollout

The government began 2021 with an ambitious target of vaccinating 67% of the population (40 million) by the end of 2021 but was to experiencing challenges with procurement and distribution, and then with low demand, including ‘vaccine hesitancy’. The shaky start to South Africa’s vaccination campaign continued into April 2021, with the Minister of Health announcing on 13 April the suspension of the Janssen vaccine, following concerns raised by the USA’s Food and Drug Administration (FDA). The suspension was lifted on 23 April, although with certain protocols in place.⁵

On 25 June the Economic Freedom Fighters (EFF) marched on SAHPRA claiming that it favoured Western capitalist interests and discriminated against Russian and Chinese vaccines including Sputnik V and CoronaVac. It also made personal allegations against the head of SAHPRA, Professor Helen Rees. These charges were strongly denied by SAHPRA which emphasised its role as an independent, science-based agency which follows consistent processes without favour to protect the safety of the public.⁶ At the time SAHPRA was processing the CoronaVac application which was approved on 3 July.

By June 2021, the government reported that vaccine supplies had stabilised.⁷ At the end of June, 3.1 million Pfizer doses arrived, with 2 million J&J doses arrived shortly afterwards. In July, an agreement was reached between the European Union and African Union for the accelerated delivery of J&J doses to Africa, including, South Africa, from late July, and with the United States to provide vaccines through the COVAX facility. There were also announcements that Aspen would beginning vaccine manufacturing for the African continent at Gqeberha (Nelson Mandela Metro) and the Biovac Institute in Cape Town would manufacture the Pfizer-BioNTech COVID-19 vaccine for distribution on the continent.

Increasingly, the major constraint on the rollout was vaccine hesitancy. On 13 August the Department of Health affirmed the stable supply but indicated that the demand remained low, especially within the 35 to 50 age group, and among men generally. In March 2022, health officials indicated that around 100 000 doses of the Pfizer vaccine were at risk of being destroyed because of the low uptake.

⁵ SAHPRA press release, 17 April 2021. Online at <https://www.sahpra.org.za/news-and-updates/sahpra-statement-update-on-sisonke-phase-3b-implementation-study/>

⁶ SAHPRA Press Release, <https://www.sahpra.org.za/press-releases/sahpras-response-to-the-economic-freedom-fighters-eff-march/>

⁷ President Ramaphosa’s statement on 15 June. Online at <http://www.energy.gov.za/files/docs/Presidents-Message15062021.pdf>

Economic and Livelihood Support

Providing continued social support remained important although there were signs of an economic comeback. In July, the UIF extended the Covid-19 TERS scheme to sectors affected by the Level Four restrictions. By that time around R60 billion had been expended through the scheme to protect over 5 million jobs.⁸ Other measures to support small business included the extension of the Employment Tax Incentive. The Covid Social Relief of Distress Grant had come to an end in April 2021 but on 25 July, the President announced that it would be reinstated until March 2022. During the February 2022 State of the Nation Address, President Ramaphosa announced the extension of the Covid grant for another year.

The Fourth Wave (Omicron)

The story of the Fourth Wave begins dramatically in November 2021, with the discovery of a multiply mutated version of the virus in Gauteng testing laboratories at the same time as the increase in reported infection.

In early November a technician in the Lancet laboratory in Tshwane (Pretoria) observed a viral sample with an unusual feature - the S-gene couldn't be detected in the testing suggesting that it had mutated. When further samples were identified with the same anomaly, Lancet, and other members of SA's Network for South Africa's network for genomics surveillance, performed DNA sequencing. with the data provided to the NICD. By 22 November the NICD had determined that there was a new variant of the virus – the B.1.1.529.

DNA sequencing of samples taken from individuals who had left Botswana on 11 November, and from a man who returned to Hong Kong from SA on the same day, also revealed the presence of the mutated virus. The virus was spreading fast through Gauteng and into other provinces by the third week of November, but the place of origin could not be determined.

Events moved quickly. The NICD reported its findings to the WHO on 24 November which classified it as a 'variant of concern' and termed it 'Omicron' on 26 November. Over the next two days countries across the world placed travel restrictions on SA including flight bans. The UK placed SA on its 'red list'. The WHO said that these restrictions undermined global solidarity in fighting the virus and would have minimal effect on the rate of spread, and President Ramaphosa called the restrictions 'deeply disappointing'.

SA was the first country internationally to enter the Fourth Wave with the highly transmissible Omicron quickly outcompeting Delta. Levels of infections soon exceeded that of the previous waves but preliminary data from Tshwane, the first global epicentre of the new wave, indicated that Omicron was

⁸ Presidents Message, 11 July 2021. Online at <http://www.energy.gov.za/files/docs/Presidents-Message11072021.pdf>



milder than previous variants, with fewer hospital and ICU admissions, and a significantly lower death rate. The mean age of infections was lower, and more children were infected, but there were few health complications.⁹

An interregnum

This decoupling of deaths from infections led some to believe that Omicron marked the final phase in the pandemic. With the mild nature of the Fourth Wave, the government maintained South Africa on Alert Level 1. On 31 January, as South Africa was exiting the Fourth Wave, Cabinet approved changes to Covid regulations which included *inter alia* reducing the isolation period for infected individuals from 10 to 7 days and removing the requirement for infected individuals with no symptoms to isolate. On 7 February full-time schooling was resumed.

On 15 March draft regulations for managing Covid were released by the Department of Health. These were intended to be introduced when the government lifted the national State of Disaster. These provoked a controversy, with leading academics calling the regulations ‘unrealistic and oblivious to the new realities of Covid’.¹⁰ A study based on a sero-epidemiological survey from October 22 to December 9, 2021, in Gauteng Province, indicated that there was ‘widespread underlying SARS-CoV-2 seropositivity before the Omicron-dominant wave’.¹¹ These findings informed a criticism that the lockdown measures had failed to contain the spread of the virus, while causing a disproportionate burden on the economy and livelihoods.¹²

A fifth wave?

Experts warned of a fifth wave during the winter and by the end of April 2022 there was an increase in Covid-19 infections, driven by the BA.4 and BA.5 Omicron sub-variants. At about the same time, research findings were released which showed that by the end of the fourth wave 87% of South Africans may have been infected by the virus, and just over 97% some form of immunity because of previous infection or vaccination.¹³ Both New York Times and Bloomberg published articles pointing out that

⁹ A study released in mid-December indicated that ‘comparing the Omicron and previous waves, deaths and ICU admissions were 4.5% vs 21.3% and 1% vs 4.3% respectively; length of stay was 4.0 days vs 8.8 days; and mean age was 39 years vs 49.8 years’ See [https://www.ijidonline.com/article/S1201-9712\(21\)01256-X/fulltext](https://www.ijidonline.com/article/S1201-9712(21)01256-X/fulltext). A Discovery Health study indicated that children under age 18 have 20% higher risk of admission for complications of COVID-19, when infected with Omicron, but admissions for hospital for complications remains low.

¹⁰ See Mendelson, M., Madhi, S., Nel, J., Gray, G., Osih, R. and F. Venter (2022) The incoherent and illogical new government Covid-19 regulations are the real state of disaster, *Daily Maverick*, 22 March, <https://www.dailymaverick.co.za/article/2022-03-22-the-incoherent-and-illogical-new-government-covid-19-regulations-are-the-real-state-of-disaster/>.

¹¹ Madhi, S., Kwatra, G., Myers, J. E., Jassat, W., Dhar, N., Mukendi, C. K., ... & Mutevedzi, P. C. (2021). South African population immunity and severe Covid-19 with omicron variant. *MedRxiv*.

¹² See also Ven den Heever, A. (2022) ‘It’s such a botch’: SA’s vaccine delays and Covid lockdown proved deadly. <https://www.dailymaverick.co.za/article/2021-03-28-its-such-a-botch-sas-vaccine-delays-and-covid-lockdown-proved-deadly-prof-alex-van-den-heever/>

¹³ The study was conducted by Stellenbosch University’s DST-NRF Centre of Excellence in Epidemiological Modelling and Analysis and the South African National Blood Service, and was based on an analysis of 3,395 samples from blood donors.

South Africa had entered a fifth wave despite these very high levels of immunity suggesting that the virus was continuing to evolve to dodge immunity.¹⁴

The fifth wave was mild, with the 7-day reported case average peaking at around 8 000 by 11 May compared with the 23 000 during the fourth wave. Hospitalisations were low, with peak hospitalisations of around 3 200 compared with 16 800 for the third wave and 9 400 in the fourth. Daily deaths peaked on the 7-day average at 50, compared with around 270, 550, 430, and 210 for the previous waves respectively. The low hospitalisation and death figures had partly to do with the lower rates of infection than previous waves and higher levels of immunity but also because Omicron and its sub-variants had replaced the other, far more deadly, variants. Deaths were now largely decoupled from cases and international data suggested that fatality rates for Omicron variants were now similar to that of influenza. By early June the fifth wave – if it could be regarded as a wave – was effectively over, and death rates in South Africa were approaching the pre-Covid average of around 12 deaths per 100 000 persons per week.

It was however time to take stock of Covid-19 deaths. By 13 August, there were an estimated 326 671 excess deaths since 3 May 2020, or 529 deaths per 100 000 of the population (ranging from 383 in the Western Cape to 790 in the Northern Cape). It was estimated that 85-95% were directly attributable to Covid-19 with the remaining the consequence of stress on the health system during the pandemic.¹⁵

The protracted end to the regulatory regime

Towards the end of 2021, citizens, the private sector, political parties, and other lobby groups became more and more vocal about the end of the national State of Disaster¹⁶. After over 20 extensions, the Government had to find a sustainable solution to exit the State of Disaster. The major concern was that ending the State of Disaster terminates all related regulations. With a possibility of a 5th wave, the Government had to ensure some of these regulations continue. However, the process followed as well as the mechanisms used to continue regulations is questionable. The Minister of Health and the Minister of Employment and Labour published new regulations under the Public Health Act of 2003 and the Hazardous Biological Agents Regulations on 16 March 2022. However, these regulations were sharply criticised by scientists and academic as being unrealistic and unnecessary. The Regulations

¹⁴<https://www.nytimes.com/2022/06/01/world/africa/omicron-south-africa-antibodies.html>;

<https://www.bloomberg.com/news/articles/2022-05-30/s-africa-had-fifth-covid-wave-despite-97-antibody-protection>

¹⁵ South African Medical Research Council report on weekly deaths in South Africa: 29 December 2019 to 13 August 2022. <https://www.samrc.ac.za/reports/report-weekly-deaths-south-africa>

¹⁶ Evans, J. 2022. Premier Alan Winde wants urgent President's Coordinating Council meeting to end state of disaster. News24, 4 March; Du Plessis, E., van Niekerk, D., Rosenkranz, B. & Preiser, W. 2022. After the COVID-19 state of disaster in South Africa. *Nat Hum Behav* 6, 901–901.

concern all forms of hazardous biological agents which includes Covid-19. The regulations are read in conjunction with the “Code of Practice: Managing Exposure to SARS-COV-2 in the Workplace” which became effective upon the termination of the national state of disaster.

Exiting the State of Disaster

The regulatory regime in response to Covid-19 came to a somewhat jumbled end. Controversies had erupted in February and March 2022 with threats of legal action as the government maintained the national State of Disaster despite the mild nature of the dominant Omicron variant.

The State of Disaster was lifted on 5 April 2022. The Government had no specific plan on how to exit such a prolonged period of a national State of Disaster, besides having ample time to put plans in place. When President Ramaphosa announced the lifting of the national State of Disaster with effect from 5 April, government put in place transitional measures, including the wearing of face masks in indoor public spaces, and restrictions on the size of gatherings for a further 30 days. However, when the regulations expired on 4 May, the government was concerned with an impending 5th wave of infection and so the government gazetted a set of new regulations under the Public Health Act, 2003 which effectively extended the 30-day measures.

The fifth wave proved to be very mild and was over by early June. On 22 June the government withdrew the regulations and so the Covid-19 regulatory regime was over. However, controversies of the nature of the regulatory regime remained with, for example, the Supreme Court of Appeal confirming that the government acted illegally in banning tobacco products during the lockdown.

Disaster management at national and provincial government levels

Sector-specific responses by national government departments

The National Department of Health (NDoH) was at the coal-face of managing the direct effects of the COVID-19 pandemic. The first year of the pandemic focused on developing the clinical response to the virus, formalizing protocols and developing and implementing management systems that enabled the sharing of information (e.g. through the EVDS) and resources (e.g. hospital beds) between the public and private health sector. This supported more efficient management of the health response during the second and subsequent waves of the pandemic. The focus of the NDoHs efforts broadened once vaccines became available. The global fight to secure vaccines was characterized by pre-orders by nations with stronger fiscal ability, blocking sales to other countries. South Africa was in a precarious position as it was unable to order vaccines through the normal production pipeline due to preorders by other nations, and was not earmarked as a country that requires assistance in procuring vaccines. The implementation of a mass vaccination programme necessitated difficult decisions to balance the

demands and needs of various stakeholders with available storage, distribution, capacity and financial resources of the department. Some functions performed by the NDoH could have shifted to other departments to free up capacity, e.g. the transport of vaccinations. The vast share of the National Health Initiative (NHI) was committed to the COVID-19 response, rendering some sustainable foundations for the NHI, including the integrated electronic patient record database and a precedent for sharing and integrating public and private health sector resources.

The responses from other sectors reveal three trends. First, the continued support to the sector to mitigate and recover from the financial shock caused by various lockdowns. Relief funds focused on those most vulnerable, e.g. small scale farmers, employees with reduced working hours, and emerging artists and while the support was appreciated, respondents indicated that in most cases the available financial support was insufficient to compensate the loss suffered. “The funds were quickly disbursed and this was not enough to recover. It provides only a short-term buffer to keep the door open, but money keeps flowing out of the business and it needs a sustained income.”¹⁷ Rather, “what worked was when we realised that putting money into the sector will not save the sector, rather findings ways to operate within the midst of the pandemic [by putting] in place the relevant protocols.”¹⁸ This presents the basis for more effective disaster mitigation in future shocks.

A second trend is a returned focus on pre-COVID priorities and existing programmes of the department that were either halted due to lockdown in 2020 and the shift to online working arrangements or placed on the back burner to redirect resources to manage critical implications of the COVID-19 pandemic. Some departments indicated that the return to prior programmes was strengthened by the improvement in databases and communication with the sector, but that these systems require further development to facilitate communication and adaptive support to the sector in the case of another disaster.

Thirdly, the degree to which sectors investigated and captured the lessons learned from the pandemic varied across departments. While some commissioned reports to investigate the effect of the COVID-19 response and mitigating measures on the sector, others indicated that they have not assessed the effect of provided support on the capacity to cope and recover from the pandemic.

With the return to “business as usual” there seems to be a lost opportunity to reflect on the implemented measures that restricted or supported each respective sector, and a focus on strengthening building blocks that will improve the capacity to respond to future shocks through improved risk planning, adaptive management and rapid implementation of appropriate responses.

¹⁷ Interview with the Director-General of the National Department of Tourism. 6 December 2021.

¹⁸ Interview with the Director-General of the National Department of Tourism. 6 December 2021.

Provincial patterning and response

While the Third Wave was more severe than the previous waves there were significant provincial and local variations. The table below is indicative of the difference but there is more complexity as the curves took very different forms across the provinces (and the exact date of peaking is contestable). The point here is simply that there was significant regional variation but the responses in terms of alert levels and linked regulations were nationally uniform. Interestingly, though, the Fourth Wave was rather more time concentrated than the Third Wave, possibly because of Omicron's high levels of transmissibility and the high levels of mobility during December.

Table 1: Third and Fourth wave peaks per province

	E.Cape	Free State	Gauteng	KZN	Limpopo	Mpumalanga	N. Cape	N. West	W. Cape
Third Wave Peak	3 Sept	26 Aug	2 July	21 Aug	16 July	16 July	26 Aug	8 July	6 Aug
Fourth Wave Peak	23 Dec	15 Dec	12 Dec	15 Dec	12 Dec	12 Dec	24 Dec	12 Dec	24 Dec

Source: Authors' own

The First Edition of this Chapter has detailed the provincial and municipal responses to the pandemic. Interviews after the Third Wave indicated that there had been no substantive changes to the management of the pandemic within provinces and there are also no indications of a significant shift into the Fourth Wave. The institutional architecture from the previous waves has remained largely intact, with national uniformity (e.g., in the determination of Alert Levels), rather than provincial differentiation, continuing to apply. Provincial respondents did however indicate that national regulations were more targeted than before and had less negative impact on economic activity and livelihoods.

There has, however, been adaptation and fine-tuning of approaches, with all provincial respondents indicating that they were better placed to manage the Third Wave than the first two because of experience and learning, despite its generally greater severity. There was, however, quite considerable variation in circumstances, and some continued difference in provincial orientation.



Gauteng was in the eye of the storm in the Third and Fourth Waves and faced media criticism for a lack of preparedness. During May there was a “hospital bed alert in Gauteng”¹⁹, and warnings of a “very severe third wave in Gauteng”²⁰ with modelling commissioned by the NICD projecting significantly higher infections than the Second Wave. Gauteng did indeed experience the most severe impacts. Nevertheless, on 9 July 2021 international media reported doctors in Johannesburg described the system as ‘beyond its breaking point’, with insufficient beds and barely enough oxygen.²¹

The provincial Health Department was criticised for entering the pandemic with its largest Covid facility closer due to the fire at the Charlotte Maxeke Hospital, and for having closed the Nasrec Covid-19 field hospital facility which had been underutilised in the first two waves. The Department countered the criticism by arguing that it had more beds available during the Third Wave than during the First and Second with significantly expanded capacity in the Chris Hani Baragwanath Academic Hospital, and in smaller facilities.²² Officials argues that they managed better than indicated in the press, and that their failure was inadequate communication. Nevertheless, at the peak of the Third Wave, Gauteng hospitals were under severe pressure with bed shortages and patients transferred to hospitals outside the province.

The Western Cape had a less severe Third Wave. It fine-tuned its data-based and modelling-driven approach. Its’ well-established hotspot management approach, with area-based coordination teams, continued to work, despite the more general spread of the virus, because of improved data and quicker response capacities. Overall, Western Cape managed in terms of bed- and staff-capacity through its integrated system across public and private hospitals which allowed for a daily reallocation of resources during the peak of the Third Wave. However, the province did experience periodic shortage of oxygen because of the high demand in other provinces, especially Gauteng. The Western Cape has argued strongly for greater regional targeting in response, referring to the increased variation in the patterning of the pandemics during the Third and Fourth Waves.

KwaZulu-Natal had entered the pandemic with a community-based approach to health management called *Operation Sukuma Sakhe* (OSS) which had been deployed with some success during the HIV-Aids pandemic. This bottom-up, ward-based approach was at apparent odd with the more top-down

¹⁹ Shoba and Mthethwa, 2021, Hospital bed space alert in Gauteng as third wave of Covid-19 takes hold, 23 May, *Maverick Citizen*. <https://www.dailymaverick.co.za/article/2021-05-23-hospital-bed-space-alert-in-gauteng-as-third-wave-of-covid-19-takes-hold/>

²⁰ Professor Francois Venter, head of the research group Ezintsha at the University of the Witwatersrand, cited in Pitt, R. (2021) Wits research professor warns of ‘a very severe third wave in Gauteng’, 30 May, *Daily Maverick*, <https://www.dailymaverick.co.za/article/2021-05-30-wits-research-professor-warns-of-a-very-severe-third-wave-in-gauteng/>

²¹ McKenzie, David ("[Southern Africa hoped it was through the worst of Covid-19. Then the Delta variant arrived](#)"). CNN. Retrieved 9 July 2021.

²² The additional capacity included a 500-bed facility at Chris Hani Baragwanath, 183 bed at a facility in Carletonville, 300 beds at the George Mukhari Hospital, 300 at Jubilee Mall (Hammanskraal), and 150 at Bronkhorstspuit (Zali et al. 2020).

directive approach to handling the Covid pandemic. Although the national approach does cascade down from the NCCC, the main levels of response sub-nationally are provincial and district (which connects also to government's District Development Model – DDM). Towards the end of the Second Wave some provinces had recognised the need to develop pandemic response structures down to ward level, with KwaZulu-Natal having a seeming advantage with the OSS already in place. An analysis of the effectiveness of the OSS during Covid would require detailed on-the-ground investigation. Provincial officials have affirmed the value of OSS, although indicating uneven performance across the province. During the Third Wave, provincial government worked to integrate the processes of the DDM and OSS. With the civil unrest during the second and third weeks of July, KwaZulu-Natal faced a compound crisis. Containing the unrest, and dealing with the aftermath, did divert attention away from addressing the pandemic. This is indicated in the decline in the vaccination rate during the unrest, but KwaZulu-Natal was fortunate to have a mild Third Wave (probably due to the high seropositivity as a legacy of the second wave). Provincial officials reported that the Third Wave was 'manageable' although it took its toll on officials across all levels because of the material and psychological impacts of the coinciding civil unrest.

Despite specific concerns in individual provinces, the Third Wave was reportedly managed better, with more targeted action, improved coordination, and more efficient processes. It was a case of learning by doing.

The Fourth Wave came as a considerable shock nationally with considerable disruptions to international travel, and the summer season tourist trade. Its public health impacts were however muted and there were no reports of major pressure on health facilities. The framework for managing the pandemic remained in place, across all levels. The fifth wave was milder still, and there was no indication of significant pressure on provincial health systems. The longer-term issue, however, is whether provincial health systems emerged stronger or weaker from the pandemic. This question requires targeted research for an answer but in July and August 2022, in the wake of the Covid-19 regulatory regime, there were reports of collapsing health care in parts of the Eastern Cape²³, and extreme levels of corruption in Gauteng hospitals²⁴.

By early 2022, however, the focus was not as much on pandemic management as on the vaccination campaign, and there were significant degrees of provincial variation in vaccination levels, requiring

²³ Ellis, E. (2022) Nelson Mandela Bay state hospitals face collapse – doctors resign on 'unprecedented' scale, *Daily Maverick*, 18 August 2022. <https://www.dailymaverick.co.za/article/2022-08-18-nelson-mandela-bay-state-hospitals-face-collapse-doctors-resign-on-unprecedented-scale/>

²⁴ Van der Heever, A. (2022) How do you stop a hospital heist? Appoint a plunder-proof board. 18 August 2022. <https://www.news24.com/news24/analysis/analysis-alex-van-der-heever-how-do-you-stop-a-hospital-heist-appoint-a-plunder-proof-board-20220818>

explanation. By the end of July 2022, the variation was from around 44.9% for KwaZulu-Natal to 60.8% for the Free State:

- Free State – 60.8%
- Western Cape – 57.8%
- Limpopo – 57.6%
- Eastern Cape – 55.2%
- Northern Cape – 52.4%
- North West – 49.7%
- Gauteng – 48.4%
- Mpumalanga – 46.3%
- KwaZulu-Natal – 44.9%.

The question is whether the differences can be explained in terms of the supply side (that is, the efficacy of provincial-level vaccination programmes) or in terms of the demand side which may be shaped by a variety of contextual factors. It is difficult to disentangle the factors but there are indications.

In terms of the supply side, data shows that after the third wave, there was a sharp decline in some provinces in the number of sites at which vaccinations were supplied, most notably the Eastern Cape and KwaZulu-Natal. When the arrival of the Omicron variant was announced, there was a surge in demand for vaccines, and these provinces struggled to respond. The Vooma weekend, when government incentivised vaccinations through providing free transport to vaccination sites, also provided an indication of the differences in provincial capacity, with specific problems indicated in Gauteng, North West and KwaZulu-Natal, and in the Eastern Cape where a significant increase in the number of vaccination sites for the weekend did not stimulate a proportionate increase in vaccinations.²⁵

KwaZulu-Natal is the province where there was the most apparent variation across time. The province did well in the early stages of the vaccination campaign. The province lost some impetus during the July 2021 unrest but seemed to recover. However, from around October 2021, KwaZulu-Natal was falling behind other provinces, and was the worst performing province by January 2022. The floods of May 2022 seemed to have had a further depressing effect.

Demand side factors may explain a greater proportion of the variation. Data at a sub-district level suggests very low levels of vaccination in urban informal settlements, and that places with a higher proportion of residents within informal settlements have lower levels of vaccination. This may partly

²⁵ The Free State, Eastern Cape, and the Western Cape, were able to bring on the largest proportion of new sites to meet the anticipated demand, but Gauteng, North West, KwaZulu-Natal, and the Northern Cape struggled. Gauteng, North West, and KwaZulu-Natal, did in fact have the lowest percentage increases in rates of vaccination during the Vooma weekend, but the Northern Cape did well despite the limited additional capacity. At the higher end, the picture was mixed with the Free State having the strongest positive response in terms of vaccination rates, and the Eastern Cape the lowest.

explain the relatively low rates of vaccination in Gauteng's metropolitan cities. An age breakdown of vaccination rates suggests also that disaffected young people in Gauteng and KwaZulu-Natal may have affected overall levels of vaccination. More analysis is however required.

National Covid-19 vaccine roll-out

The national Government is responsible for procuring, distributing, and overseeing the roll-out of Covid-19 vaccines in South Africa, including distribution to provincial governments and the private sector²⁶. South Africa began the national Covid-19 roll-out in February 2021, through the Sisonke phase 3b trial. This was followed on 17 May 2021 by the national roll-out proper. Two vaccines, the Johnson and Johnson viral-vector and Pfizer-BioNTech mRNA vaccines have been used in the national Covid-19 vaccine rollout, which was implemented in a phased manner according to a national prioritisation framework. The Government's target was to vaccinate close to 40 million adult South Africans by the end of 2021, but by 04 September 2022 only 20.4 million adults (51.2%) had been vaccinated. Various governance arrangements were put in place for ensuring that the national roll-out is evidence-formed, participatory, and timely.

The South African Health Products Regulatory Authority (SAHPRA) was responsible for monitoring, evaluating, investigating, inspecting, and registering COVID-19 vaccines in South Africa. When a vaccine has been found to be safe and efficacious in phase 3 trials, the vaccine manufacturer would apply to SAPHRA for approval or licensure. The latter reviews trial results and decides whether to license the vaccine for use in South Africa or not. SAPHRA should only license a vaccine if it is satisfied that the vaccine is safe and efficacious, and the vaccine's beneficial effects outweigh potential risks. During the pandemic, SAPHRA had the authority to grant an emergency use authorisation for a vaccine prior to full approval. Section 21 of the Medicines and Related Substance Act 101 of 1965 (Medicines Act) is a mechanism that enables emergency use access and enables SAHPRA to authorise the use of medicine subject to certain conditions.

Once a vaccine is licensed, and rolled out in human populations, there is a need to monitor people who receive it to collect additional data on safety and effectiveness. A Ministerial specialist committee, the National Immunisation Safety Expert Committee (NISEC), assist SAPHRA in monitoring the safety of Covid-19 vaccines. NISEC reviews and assesses severe adverse events following immunisation to establish whether or not they are associated with the use of the vaccine. This is called causality assessment. During the pandemic, SAHPRA worked closely with NISEC to ensure that all reported severe adverse events are firstly investigated by the provinces, and thereafter assessed for causality by NISEC.

²⁶ NDOH. 2021. Vaccine information portal. <https://sacoronavirus.co.za/vaccine-updates/> (Accessed 17 October 2021) [Online]. [Accessed].

On 16 March 2021, SAHPRA provided emergency use approval of Pfizer mRNA vaccine, in terms of section 21 of the Medicines Act, for use in adults aged 18 years and older. Later, 10 September 2021, SAHPRA the use of the vaccine in terms of Section 21 of the Medicines and Related Substance Act 101 of 1965 (The Medicines Act to include individuals 12 years of age and older. On 25 January 2022, SAPHRA provided full approval for the Pfizer vaccine to for active immunisation to prevent Covid-19 in individuals 12 years of age and older. On 31 March 2021, SAHPRA approved the use of the Janssen Covid-19 vaccine for individuals 18 years of age and older as a single primary vaccination dose. The regulatory decisions of SAHPRA regarding Covid-19 vaccines do not translate into a procurement decision by Government as SAHPRA's mandate is limited to the safety, quality, and efficacy of vaccines. The Ministerial Advisory Committee on Covid-19 Vaccines is responsible for providing evidence-informed advice to the Minister of Health on the use of Covid-19 vaccines in the national vaccination programme.

Through an open-label phase 3B implementation research study known as Sisonke²⁷, South Africa made the single-dose Johnson and Johnson vaccine immediately available to nearly 500,000 healthcare workers between 17 February and 17 May 2021 before the national rollout of COVID-19 vaccines in the country, which started on 17 May 2021. Following the Sisonke study, the national COVID-19 vaccination rollout started in South Africa on Monday 17 May 2021. Two vaccines are offered in the national rollout, the single-dose Johnson and Johnson viral-vector vaccine as well as the two-dose Pfizer-BioNTech mRNA vaccine. By 05 September 2022, close to 38 million doses of COVID-19 vaccines had been administered in South Africa. Having adequate supplies of vaccines and the processes in place to administer them are not sufficient to ensure optimal vaccine uptake. Various surveys have shown that, on average, one-third of South Africans could be categorised as vaccine hesitant; but the prevalence varies across time and place. Faced with this level of vaccine hesitancy, and the need to provide a safe working environment, various companies in South Africa instituted mandatory vaccination.

Role players and relationships

The COVID-19 pandemic provided a common ground for discussions, negotiations and collaborations between government departments and across the public and private sectors. Respondents indicated that the “ministerial advisory teams in the work streams were helpful to engage with national treasury on issues that affected the sector, deal with sister departments and make them aware of challenges in the sector and how to support, engage with the banks.”²⁸ Engagement with business and civil society was important to appreciate the effect of lockdown measures and to identify possible areas neglected or omitted from government support measures and existing platforms like NEDLAC played a critical role

²⁷ SISONKE. 2021. Sisonke study: a pragmatic real world phase 3b clinical trial of the single-dose COVID-19 vaccine candidate among frontline healthcare workers in South Africa. <http://sisonkestudy.samrc.ac.za/> (accessed 17 October 2021) [Online]. [Accessed].

²⁸ Group interview with the DDG and various Chief Directors from the Department of Sports, Art and Culture. 21 April 2022.

in facilitating these discussions. In the health sector negotiations around the procurement of private facilities required timeous individual negotiations with every provider and doctor to agree on procurement prices to adhere to the equal competitions laws. Some respondents also expressed appreciation for communication and technical support from the media and telecommunication sectors. The pandemic emphasized the importance of non-governmental structures and the need to strengthen these structures to build a more resilient disaster management response that is less dependent on the government. One respondent remarked that a pandemic required decisive decisions and this may limit opportunities for negotiations with everyone.²⁹ To maximize inclusive and accountable decisions under emergency conditions, platforms for public, private and civil stakeholder engagement and joint implementation need to be established and strengthened, supported by accountable emergency procurement protocols.

Lessons from the Covid-19 pandemic

Learning from the first wave, disaster response contributed significantly to better disaster risk management in subsequent waves. However, "unseen" vulnerable groups in all provinces needed more and better attention to address their particular needs. To this end, it became clear that Government lacks a "whole of system" approach and understanding. The use of data improved but integrated systems would have added more value to the humanitarian response. Disaster risk management coordination must occur from the highest office. Therefore, the placement of DRM Centres at all levels needs urgent attention. Disaster risk management must be implemented across all sectors as per the requirements of the DMA and NDMF. Better preparedness planning of future hazards, led by the appropriate government cluster, is needed. The wisdom of having a security cluster managing disasters needs to be reassessed. Disaster risk management capacities and budgets at the national and provincial levels are inadequate and must be addressed. The DMA and NDMF needs to be amended by critically reflecting on the lessons learned over the past three years. These amendments must not primarily be aimed at better disaster response, but rather building a resilient multi-sectoral and multi-sphere disaster risk management system which caters for a whole-of-government approach to reducing the risks of disasters.

Emerging successes

COVID-19 raised awareness and conscientious of the importance of disaster management. It also strengthened legal expertise in many departments to efficiently draft regulations. While in the shorter term many sectors have adopted recovery plans, long-term progress depends on the adoption of risk management plans. Various departments have approached the NDMC to understand the requirements of the Disaster Management Act and the requirements of appropriate disaster management planning. In November 2021 the NDMC reported a total of 147 disaster management plans in place. This need to

²⁹ Interview with the DG of the National Department of Health. 17 November 2021.

be further expanded to ensure that all departments and public entities adopt a robust disaster management plan for their sector to increase their readiness to respond to disasters and risks as these emerge.

The pandemic fast-tracked the development and rollout of electronic platforms, more inclusive databases, internal and external communication systems and other relevant information technology systems to support the work of the sector. The implementation of these systems and the fast-tracking of e-service portals place the government in a better position to obtain up-to-date information relating to the sector, identify ongoing and emerging trends, and adopt policies or programmes that provide targeted support to encourage development in particular areas.

The period catapulted government departments forward to digitise processes, and spaces and bring in more flexible working arrangements. Some departments reported an increase in executive-level productivity as a result of the move away from office-bound working arrangements. Respondents again commended the hard work and commitment of staff to continuously respond to the pandemic. Departments reported a cost saving in terms of travel with the move to electronic rather than face-to-face meetings. However, as some stakeholders and sectors found the shift to online meetings harder and required data support to participate in meetings, some funds were redirected to facilitate participation. A hybrid system can present a feasible way forward.

The importance of consultation with social partners to facilitate buy-in to critical decisions and the successful adoption and implementation of interventions were highlighted. Similarly, diplomatic relations were improved as a result of ongoing discussions to manage the pandemic. It is important to continuously nurture these relationships and engage with the sector on policy and implementation matters beyond the state of disaster.

Sectors that were not subjected to hard lockdown (e.g. Agriculture and Mining) were relatively better off to mitigate and recover from the economic effects of the pandemic. Nuances emerged in hard-hit sectors, for example in the tourism sector smaller, rural travel destinations adapted easier than city hotels and mass events that require large numbers to attain feasibility. The extended closure of international borders remained problematic in the tourism sector. A more targeted lockdown strategy with a focus on restricting movement may have lessened the impact and reduced recovery time for sectors affected by the hard lockdown.

In the health sector, the phased-in mass vaccination programme reached a good percentage of people in high-risk groups with the NDoH Electronic Vaccination Data System reflecting 71,4% single dose and 66% full vaccination for those older than 60 as of 16 August 2022. Table 1 reflects a fair uptake across all age groups as well, especially when the relative risk of death and hospitalisation for younger groups

are considered. Further successes in the health sector include the implementation of a digital vaccination certificate, a loss of only 2% of vaccines due to mismanagement during roll-out and South Africa's critical role to waive the intellectual property on vaccines to obtain more vaccines for Africa and South Africa. The electronic information system was developed mostly from the existing departmental budget and the system may not yet be optimal. Additional support from various nongovernment organisations (e.g. PEPFAR, Right to Care, Wits health consortium, DG Murray trust) was critical to enable the development of the system. Investment in data and information systems is critical to ensure access to information and facilitate efficient responses to emergencies.

Table 1: Vaccination coverage (16 August 2022)

16-August 2022	At least one dose	%	Fully vaccinated	%
% Total pop.	22,213,805	36.8%	19,272,152	32.0%
% Adult pop.	20,307,956	51.0%	18,520,699	46.5%
60+	3,932,125	71.4%	3,635,615	66.0%
50 - 59 yrs	3,212,266	66.7%	3,076,717	63.9%
35-49 yrs	6,400,054	54.8%	6,014,634	51.5%
18-34 yrs	6,760,598	38.0%	5,792,375	32.6%
12-17 yrs	1,905,849		751,453	
Booster doses	3,649,583			

Source: NDoH Electronic Vaccination Data System

Mandate, coordinate and funding of DRM

At the national level, the coordination of the pandemic through the NATJOINTS continued in 2020/1. The NDMF requires each sector and organ of state to identify a DRM focal point, which must coordinate with the DRM structures created by the DMA. In most sectors and spheres of Government, there is an apparent lack of such sectoral focal points. There was general agreement that pandemic management would have been much more effective if these sectoral focal points and disaster risk management structures had been in place (before 2020). The role of the security cluster in coordinating non-security hazards, vis-à-vis the DRM structures explicitly created by the DMA for this purpose, needs scrutiny. The provinces clearly articulated such a need, and the use of the security cluster was heavily criticised by academics and civil society actors. However, the coordination by the NATJOINTS heightened the

awareness of DRM within related sectors. This allowed the NDMC to use this momentum to improve horizontal and vertical integration of DRM into national sectors and advocate for the multisectoral mandate of DRM. Also, changing the Covid-19 coordination structures "mid-flight" would not have yielded better results. Cooperation with other departments notable health, human settlements, social development and transport improve considerably. This cooperation also allowed for better integration of DRM into these sectors. This is evident by the increased requests by departments to the NDMC in developing their disaster risk management plans and assistance in capacity development. By the end of 2021, 100% of all provinces, 49% of provincial departments and 60% of all national sectors had DRM plans (147 in total). These plans are not just Covid-19 specific but cover a spectrum of disaster risks. However, a unified national resilience framework is still lacking. Such a framework will mainstream resilience and disaster risk reduction into various sectors through a developmental perspective. The NDMC further capitalised on the pandemic and consolidated its staffing position, which was under strain for several years.

The success in coordination between sectors and spheres of Government had mixed reactions at the provincial level. In KwaZulu-Natal Province (KZN), there has been no strategic intent to fulfil the requirements of the DMA. Coordination could have been improved through better alignment of multisectoral actions. Although COGTA played a central role in the provincial response, the pandemic and other hazards showed that enhanced coordination between sectors is needed. For example, food security and agricultural issues were not efficiently dealt with by COGTA due to a lack of technical expertise. The provincial department of agriculture, in turn, expected better centralised coordination. Similarly, in the Northern Cape Province (NC), reporting and management of the pandemic were heavily weighted towards security-related issues (such as policing mask-wearing, border controls, and implementing the DMA regulations). In turn, the province lost sight of other essential aspects, such as social support and economic recovery. The NC learned significant lessons from the first year of the pandemic, and their coordinating structures and actions were better than in 2020. The provincial department of health fared better. However, KZN, NC and GP believed DRM is vastly underfunded in the provinces. There is no clear guidance as to what DRM funding entails, and this caused confusion. For example, KZN departments reported no funds for DRM in 2021, although underspending in various sectors was recorded. In contrast, the NC budget was cut by R5,5 billion between 2020 and 2021, placing strain on an already underfunded mandate.

Location of DRMCs

The NDMC reported heightened political interest and buy-in in DRM due to the sustained cooperation between departments during the Covid-19 pandemic. The collaboration established due to the pandemic thus positively impacted the management of other hazards and disasters, which continued into 2022. With the onset of Tropical Cyclone Eloise in early 2021, several departments mobilised assistance through the NDMC. There was an improved financial commitment by sectors, with almost

R440 million reprioritised for disaster response and recovery for the ensuing floods in Mpumalanga, KZN, Northern Cape and Limpopo provinces. However, the placement of the DRM function in Government remained an area of concern. The first Covid-19 Country Report highlighted the need to reconsider the location of the NDMC within the Government structures. This sentiment was again echoed by DRM role-players and other departments and sectors alike. The consensus in Government is that the NDMC is best placed under the highest political authority (i.e., in the Office of the Presidency). Such a placement will address the concerns with cross- and multisectoral coordination and facilitate quicker and easier cooperation. This change will assist in the correct placing of the various DRM Centres within the other spheres of Government (e.g., provincial and municipal levels).

DRM and humanitarian response

The initial response to the Covid-19 pandemic in 2020 was a huge learning curve for many sectors and departments, which enhanced the responses in 2021. The implementation lines between disaster risk management and humanitarian response in the second wave became blurred. The continued medical response to the pandemic and the increased vulnerabilities in communities (i.e., increasing economic hardship, mental health issues and social ills) had to be addressed. The impact on the economy and well-being was brought into focus. The dichotomy between saving lives and saving livelihoods under the State of Disaster and subsequent regulations were stark. The emphasis in the second/third wave was more focussed on humanitarian actions, addressing social behaviour, economic recovery, and improving vaccinations. There was an improvement in the DRM response to the subsequent waves throughout Government, including decentralised structures. The NDMC continued to ensure vertical and horizontal response integration, with regular reporting to the political structures. The NDMC remained responsible for response coordination, although certain responsibilities were delegated to the NATJOINTS and other sectors. This was mostly due to the Government's inability to separate security-related issues and disaster risk management. Within the NATJOINT structure, the NDMC were responsible for coordinating certain workstreams and continued to take a leadership role in this regard. One of the critical activities at the national level was the management of misinformation, which could have been dealt with better. No plan was implemented to address the widespread misinformation on social media platforms. However, the overall information management of the pandemic data was improved. Data from provinces could quickly be collated for improved decision-making at the national level. The private sector also played an essential role in assisting with the creation of virtual environments for data and information management and rendering other IT services to COGTA.

The WC, GP, and NC provinces emphasised the value of the well-coordinated response by district and metropolitan Joint Operation Centres (JOCs) linked to the support provided by the provincial JOC. The NC provincial JOC had to play a more leading role than in the WC and GP, which had a much more established DRM coordination structure up to the local municipal level. This is mainly due to the years of a joint response to several hazards, noticeably veld fires, floods, and storms in these provinces. The



NC experiences less frequent and intense hazards (e.g., droughts) and has fewer response capacities within municipalities. To this end, the NC relied heavily on the coordinating structures from the security cluster (ProvJoints). The NC provincial disaster management centre played more of a support than a coordinating role in the JOC (ProvJoints) compared to the WC and GP. Information provided by the Department of Health to all provinces improved the response to and management of the pandemic. A dedicated health professional in the WC disaster operation centre was valuable in the interpreting of health-related data and subsequent decision-making. The WC improved their geographical response to the pandemic by using a "hotspot" system based on the data from the Department of Health. This geographical focus improved overall response and allocation of resources (such as the distribution of oxygen to hospitals and clinics). The province was also able to capitalise on other initiatives to improve its response capacities. For example, the province used the "Red Dot" transportation system in conjunction with the Department of Transport to contract legal taxi operators to transport nurses, patients and other essential services to health facilities .

The compounded effect and additional stress on all government systems in KZN due to the civil unrest, violence and looting in July 2021 highlighted the inadequate response capacities in this province. The unrest removed the focus from the Covid-19 response, and the province struggled to ensure a coordinated response. This situation echoed in the April 2022 floods, which once again exposed the need for enhanced DRM capabilities at the highest level of decision-making in the province. The province reported issues with the use of ICT and had challenges in translating the use of their data into adequate responses at the local level. Coordination with community-based structures was improved during the second and third waves of the pandemic. Traditional, community and faith-based leaders played a crucial role in advocating for vaccinations and addressing misinformation linked to vaccine hesitance.

Limitations and failings in the response

The pandemic had disproportionate effects and impacts on different sections of the population. It was felt more by vulnerable groups such as women, youth, persons with disabilities and those employed in the informal sector who were not always able to access the support that they require³⁰. The number of people that go hungry increased, exasperated by the closing of school feeding schemes. The loss in learning and dropouts by extended school closures may be impossible to reverse. High population density impedes the adoption of social distancing and hinders the provision of safe shelter for all. The National Income Dynamics Study Coronavirus Rapid Mobile Survey (NIDS-CRAM) study reveal the high effect of the pandemic on women, but identifying the needs of vulnerable groups are hindered by a lack of data. The shift to online discussions and services makes it more difficult to reach vulnerable groups that do not have access to devices or data. Data on vulnerable groups should be collected by front

³⁰ Group interview with various Heads in the Department of Women, Youth and Persons with Disabilities. 14 March 2022.

service line departments, but many do not have appropriate data collection mechanisms in place. There was general agreement that the lack of comprehensive databases and systems to track the effect of lockdown and service the information needs of departments presented a huge challenge with most departments taking time to get their systems in place. Regardless of the nature of a future pandemic, reliable and efficient information systems will be critical to providing decision-makers with information that can help mitigate the effect of the disaster.

Shifting government service delivery to online required the procurement of new infrastructure which proved to be a protracted process. However, the state is not agile and takes months to procure even with emergency procurement. One department indicated that the procurement process to equip all staff with appropriate devices and data started in July/August 2020, with procurement concluding in January 2021 and rollout concluding in June 2021. The delayed procurement processes prevented staff from functioning productively. There is an urgent need to improve supply chain processes, especially under emergency conditions, and to increase understanding of government procurement rules in the private sector.

While administrative work was moved online, some tasks need to be performed in person and proved to be more difficult under COVID-19 protocols. The Department of Labour reports that interactions with institutions were easier online, but matters affecting individuals were more difficult. The CCMA is also challenged in terms of budget and vulnerable employees may be unable to approach the CCMA if these services are virtual and data restraints prevent access.”³¹ Similarly, onsite inspections cannot be performed virtually, but visiting sites poses a risk to the employee and the occupants of the premises that is inspected, while other vulnerable sectors, e.g. domestic workers, cannot be monitored for adherence to COVID-19 protocols. Other departments also reported first the unavailability and later delays due to backlogs of in-person services e.g. the apostilling certificates for consular purposes.

Financial support to affected or vulnerable groups was insufficient to compensate for the financial loss of the pandemic. While the relief funds buffered some of the shocks, the funds were quickly disbursed and it was not enough to facilitate recovery. Promises of support raised expectations that government could assist, but in reality, the available support was far too little for the extended periods of reduced economic activity. In the tourism sector, the pandemic influenced all provinces with a knock-on effect on production value chains, considering that a small loss in the Northern Cape may be similar to a larger loss in Cape Town when factoring in the relative size of the affected population and economy of the province. In rural Limpopo, faith/church events that introduce huge spending into the province from Zambia, Zimbabwe, Botswana and Malawi were suspended with a knock-on effect on vendors and jobs that supply accommodation, food and fuel sales to visitors. In bigger cities, mass events were not in

³¹ Interview with the Chief Director Labour Relations of the Department of Labour. 18 November 2021.

operation and the value chains that are connected to the events were also affected.³² The tourism sector still presents a high risk for those who choose not to take the vaccines. While the existing workplace safety acts provide a legal ground for enforcing vaccines, it seems that very few employers have opted for this route.

“Government cannot through grants mitigate the impact of the job losses.”³³ Relief funds provide a short-term buffer to keep the door open, but money keeps flowing out of the business, including obligations on municipal rates and taxes. In providing support to small businesses, the eligibility criteria included tax compliance, and many applicants were not compliant. This complicated matters and delayed the payment. The decision to close the whole economy including e-commerce and all areas independent of an accurate risk assessment followed by a protracted period to reopen all parts of the economy compounded the economic effect of the pandemic.

The Health sector faced several challenges while trying to manage the pandemic. The PPEs disaster was a huge disappointment and difficult to manage the public relations repercussions. The private sector became exasperated that the government was leading on vaccine procurement and policies, but not taking leadership decisions. The July 2021 riots lead to a loss in vaccination momentum throughout the entire KwaZulu-Natal province. Staff were unable to go to work or transport the vaccines and the warehouse that stored provincial supplies of chronic medicines was ransacked, as well as some of the pharmacies operating as vaccination sites.

The frequent changes in the Minister of Health deterred progress with the need to re-brief and rebuild relationships between the political and executive arms of the department. The suspension of senior colleagues and freezing of permanent appointments at senior-level posts placed the health department under additional strain to manage the pandemic, ongoing health concerns (e.g. Tuberculosis), high staff absenteeism due to sickness and the implications of a 6.5% budget cut. While additional funds were made available for the procurement of vaccines, no funds were provided for the transport of vaccines and personnel or the implementation of the electronic system as a backbone to the system. Additional support from other departments could have been helpful in some aspects, but in other cases, the involvement of multiple stakeholders increased the complexity of the work. There is a need to expand the technical capacity such as infection control specialists and information management specialists within the Department of Health instead of relying on temporary contract appointments.

Public trust is undermined when there is a lack of transparency. Finding the balance between lives and livelihoods is not always clear-cut with every decision. However, clear communication on decisions,

³² Interview with the DG of Department of Tourism. 6 December 2021.

³³ Interview with the Chief Director Labour Relations of the Department of Labour. 18 November 2021



supported by transparent MAC reports and other information that informed the decision would have improved public trust. Misinformation should have been managed more proactively to debunk issues, provide countering evidence and enables people to verify facts reported on social platforms. A clear line between administrative and political governance domains must be maintained to promote accountability. For example, politicians should not announce service delivery numbers.

COVID-19 presented important learning on managing national disasters. Without adequate institutionalisation of the disaster management function across all sectors, coordinated disaster responses remain problematic. In November 2021, all municipalities have adopted disaster management plans, while only 41% of provincial departments and 60% of national departments submitted their disaster management plans to the NDMC, presenting an overall rate of only 26%.³⁴ Plans should also consider the effect of fatigue on the staff in the various disaster management centres and adopt a business continuity strategy. It is important to separate security versus non-security incidents and provide coordinating mechanisms appropriate to the type of incident that caused the disaster.

Recommendations for future risks, responses and prevention

Efficient risk management requires appropriate national-level capacity, information management systems and procedures to effectively respond to emergency and disaster situations.

Complex emergencies and multiple hazard stressors

Complex emergencies have been studied for a number of decades. Such emergencies result from natural and anthropogenic hazards, coupled with different levels of pre-existing vulnerability and conflict³⁵. One risk can quickly escalate within complex emergencies, leading to the manifestation of other emergencies. Seen as a whole, the combination of these hazards severely strains resources and coping capacities. However, complex emergencies are rarely rapid onset events. Instead, they are brought about by years of systemic risk. The COVID-19 pandemic and multiple hazards during 2021 became a stark reminder of these complexities and inadequacies in our society. With its dualistic and struggling economy, inequality, and corruption, South Africa is riddled with compounded political, socio-economic and environmental crises. Together, these crises present societal issues that need holistic and all sector approaches. However, as the global pandemic unfolded in this period, it became more apparent that years of graft and corruption, political infighting, disregard for the rule of law, and

³⁴ Group interview with the Deputy Director-General and various members of the National Disaster Management Centre. 10 November 2021.

³⁵ Cutter, S. L. 2018. Compound, Cascading, or Complex Disasters: What's in a Name? *Environment: Science and Policy for Sustainable Development*. 60, pp. 16–25. <https://doi.org/10.1080/00139157.2018.1517518>; Hariri-Ardebili, M. A. 2020. Living in a Multi-Risk Chaotic Condition: Pandemic, Natural Hazards and Complex Emergencies. *International Journal of Environmental Research and Public Health*. 17, 5635. <https://doi.org/10.3390/ijerph17165635>

failing utilities and infrastructure have eroded the ability of the Government to address even the most basic problems. Most approaches to multiple stressors were one-sided, siloed and fragmented.

Unprecedented civil unrest and looting amid the pandemic in KZN and GP provinces showed how quickly multiple crises could impact an already overburdened government system. Besides this dire situation, another disaster has been unfolding. On 20 July 2021, the South African National Disaster Management Centre classified the drought in parts of the Northern Cape, Western Cape, and Eastern Cape as a national disaster³⁶. It became the first time in the history of South Africa that a national disaster has been declared for two different hazards simultaneously. Additional stresses were placed on government systems due to other prevalent hazards such as the African swine flu³⁷, veld fires, and taxi violence³⁸ in the Western Cape province, and the impact of Tropical Cyclone Eloise off the Mozambique coast on Mpumalanga, Limpopo, Northern Cape provinces. Disaster risk management centres had to manage these multiple hazards in a complex environment. The direct impact of Covid-19 on disaster risk management personnel and first responders further eroded the capacities at all levels of Government. Most DRM centres were not well prepared when their staff fell ill. The impact of fewer officials in many other sectors contributed to the heightened risk of certain hazards. For example, within the forestry sector in the Western Cape, failure to clear invasive alien species and remove burn load added to the risk of uncontrollable veld fires. This is quite evident in the devastating veld fires which ravaged the upper campus of the University of Cape Town in April 2021. Under normal circumstances, the biomass of flammable vegetation could have been much less due to continued maintenance. In the NC, the moist air brought inland by Tropical Cyclone Eloise had a positive effect besides the flooding that it caused. The rain resulted in a significant rise in dam levels in the province, which mitigated the prolonged dry spell experiences by the province since 2018. However, it was the civil unrest in KZN that exposed KZN's inability to manage compounded and complex risks linked to several simultaneous hazards. The lack of adequate resources was stark and focussed the attention away from the Covid-19 pandemic. These multiple hazard events once again emphasise the need for adequate and functional multi-hazards early warning systems linked to precise response, for the whole of South Africa.

Building of a resilient disaster risk management system

To better manage similar situations in the future the Government needs to instil an understanding of various management paradigms for security and non-security related hazards. Under the DMA the NDMC and related structures are accountable for the reduction of disaster risks. These statutory and regulatory instruments for DRM have been lauded as international best practices, and thus the legal

³⁶ South Africa. 2021. Government Gazette Vol. 673 No. 44876. Pretoria: Government Printer.

³⁷ <https://www.westerncape.gov.za/news/update-african-swine-fever-asf>

³⁸ <https://www.iol.co.za/weekend-argus/news/123-killed-during-the-western-cape-taxi-violence-in-2021-66c9e844-a84b-427c-b7a4-3cc2afc11d38>

status of the NDMC in the management and coordination of nationally declared States of Disasters must be respected. A resilient DRM system must be built at all levels and across all sectors. This system must be developed through the lens of human vulnerability and a scientific understanding of the various characteristics of hazards of all kinds. Such a system must exhibit anticipatory governance and an understanding of disaster risk in complex systems. It should be driven by cutting edge and up to date information systems and data, inculcate foresight and network systems, open-minded institutional culture, and the devolution of powers. A critical reflection on the DMA and NDMF must lead to amendments which will take into account the lessons learned from the pandemic. These amendments must be aimed at the development of a robust, resilience and sustainable DRM system.

Risk planning and management

Crises situations have similarities and differences. The COVID-19 pandemic prompted the adoption of protocols and implementation strategies that will enable society to better respond to a future respiratory infection or a disaster that limits movement arise. Protocols, information management and some infrastructure gains support a response by the health sector while improved information and communication infrastructure in service delivery departments provide the tools for distance working for officials. However, most sectors are still unprepared for a different types of crises as risk planning and the adoption of resilience frameworks are still nascent. Improved risk planning and management are needed to ensure that the public, private and civil society sectors can recover quicker from future crisis situations and prevent another close down of the economy or social support systems.

The appropriateness of the placement, functions and capacity of the National Disaster Management Centre (NDMC) and the Disaster Management Act should be revisited in terms of the lessons learned in the COVID-19 pandemic. The institutional location, form and post levels of the national, provincial and district disaster risk management centres should be considered to ensure that it is appropriately placed and capacitated to execute their function. Placing the NDMC in the Office of the President will increase its cross-coordinating capacity and facilitate alignment between annual planning, and disaster management plans based on comprehensive risk assessments for the sector and the budgetary implications to mitigate identified risks. The finances, data and information and human resource capacity of the NDMC could be strengthened to enable it to implement early warning systems to proactively identify emerging disaster situations. The NDMC was not yet sufficiently capacitated to digest the warnings that were coming from the international bodies.³⁹ Once a risk or potential disaster is identified there is a need for clear engagement protocols between the NDMC and sector departments that sets out roles and responsibilities and assessment criteria to identify where the existing legislative arrangements within a sector are deemed inadequate to manage and mitigate the identified risk.

³⁹ Group interview with the Deputy Director-General and various members of the National Disaster Management Centre. 10 November 2021.

Different coordination arrangements should be adopted to deal with security and non-security events. While NATJOINTS provide an appropriate response for disasters related to security, disasters with limited security implications may be better led by another appropriate government cluster.

All national and provincial departments should adopt disaster management plans and implement appropriate monitoring systems to track risks and their effect on the sector. Future pandemics will hit vulnerable groups harder. It is important to strengthen the commitment of leaders and champions of projects to ensure that planning, budgeting and project implementation increase the access and participation of vulnerable groups. Data on vulnerable groups need to be strengthened in all strategic plans, with standardised technical indicator descriptions that ensure that disaggregated data is collected at a departmental level. A central data repository within the DPME or StatsSA can facilitate access to this data for policy and planning purposes.

Financial resilience

Our ability to manage and mitigate future emergencies that may still prove to be uncertain will depend on our financial ability to provide the necessary response to the event.⁴⁰ Fiscal consolidation, monetary stability and invigorating economic growth are important to achieve financial resilience. Support packages by the government in response to the COVID-19 pandemic were appreciated, but insufficient to fully mitigate the impact of the pandemic and facilitate recovery across all sectors. The government's ability to provide support to future pandemics, especially if these occur in the short to medium term, is severely constrained and financial recovery should therefore be a primary objective. Supporting this, government sectors should identify those most vulnerable to the shock in the sector and invest appropriate support to increase the resilience of these vulnerable groups. Increased resilience will decrease the burden on the state to implement mitigating strategies, and enable faster recovery as was observed for more resilient and better-resourced stakeholders during the COVID-19 pandemic.

Robust and reliable data systems will be important regardless of the emergency faced. In some sectors, the absence of relevant data hindered communication with stakeholders and the formulation of appropriate responses as the pandemic unfolded. Robust information systems may best be promoted through dedicated funds to promote digitalisation in all sectors. Specific funding conditions should be adopted to promote appreciation of the importance of data systems and ensure that funds earmarked for data resourcing are used for this purpose.

Vulnerable groups are hardest hit in a crisis. Departments that support vulnerable groups require sufficient resources to fulfil this mandate and should facilitate the adoption of policies and information management systems that serve the needs of those most vulnerable.

⁴⁰ Group interview with various Heads in the National Treasury. 10 December 2021.

Data management

“Accurate information and information systems are a prerequisite to many other service delivery decisions.”⁴¹. Many sectors do not have appropriate data management systems in place to inform decision-making. While systems were rapidly expanded during the COVID-19 pandemic, many of these relied on support from external partners that will not provide a sustainable system for ongoing monitoring and improvement of these systems. Systems should be strengthened at the sector level, to expand the data and information needed for the sector, but also on a multi-sectoral level. There is a need to collect disaggregated data that can speak to the information needs of other sectors and to create a centralised hub where data can be stored and accessed.

Communication

The COVID-19 pandemic emphasised several shortcomings in the communication between government and society. The government’s ability to reach persons in informal settlements, vulnerable groups, and those without smartphones and data is insufficient and many people were excluded from the government’s messages. Digital Vibes that promised an improved communication platform disappeared before the promise could realise.

Communication on decisions should also extend to the rationale that informed these decisions to improve public trust and understanding and facilitate a society-wide response to the pandemic. An effective strategy to counter misinformation should be adopted.

The pandemic provided shared interest in various sectors that facilitated engagement with sector stakeholders. Engagement with sector partners through various platforms should be further strengthened to reap communication benefits beyond the COVID-19 pandemic.

The COVID-19 work streams were helpful to enable a coordinated response between government departments. Formalising coordinated engagement between government departments can strengthen intergovernmental relations and implementation.

Procurement

Supply chain management processes as set out in the Public Finance Management Act at times delayed the procurement of resources required to respond to the relevant disaster. There is a need for flexible, transparent and accountable procurement procedures to enable a faster response to procure emergency equipment or disburse relief funds. These procedures should consider the lessons learned

⁴¹ Interview with the Chief Director Labour Relations in the Department of Labour. 18 November 2021.

from procurement humiliations during the COVID-19 pandemic, but also the delays in serving and supporting communities in the face of a disaster.

E-services and distance work

The COVID-19 pandemic catapulted the government forward in the adoption of online platforms and flexible working arrangements. Strengthening the capacity to deliver e-services will increase resilience to future disasters that disrupt places of work, and ensure that services and support can be delivered when they are needed most. While COVID-19 necessitated an emergency shift to remote work and online service delivery, these arrangements should be formalised through tailored performance management contracts, appropriate performance monitoring, accountability enforcement, strengthened digital platforms and infrastructure, supported by a reliable electricity supply and tailored risk management responses.

Conclusion

The period from 1 April 2021 to 13 August 2022 included the third, fourth and fifth waves of the pandemic. This period accounted for 54.4% of excess deaths nationally to date. The third wave, driven by the Delta variant, was deadly, competing with the second wave in terms of severity. It also coincided with social unrest in KwaZulu-Natal and Gauteng. July 2021 may have been the bleakest month of the Covid-19 pandemic in South Africa. The fourth wave in December 2021 came as an immense shock, with the Omicron variant first detected in a Gauteng laboratory. In terms of daily cases, the fourth wave surpassed the previous two waves, but Omicron proved to be a relatively mild variant, and hospitalisations and deaths remained low. The fifth wave was a mere blip on the charts.

It was during this period that the vaccination campaign was rolled out. Despite a shaky beginning, the campaign gained some momentum. The campaign peaked around August 2021, with a second peak in December 2021 after the announcement of the Omicron variant. It was most successful among the elderly, with vaccination rates remaining low in international terms for the younger age groups.

The national State of Disaster remained in place until 5 April 2022, with a peak of risk adjusted level four between 28 June to 25 July 2021 during the third (or Delta) wave. The mild nature of the Omicron variant increased pressure on government to end the Covid-19 regulatory regime, but the phasing out of regulations was protracted. Although the State of Disaster was ended on 5 April it took until 22 June 2023 for controls on gatherings, mask wearing, and international travel to be removed.

While regulations were uniform nationally, there were significant provincial and local variations in the severity of the pandemic, and in terms of the efficacy of disaster management. The third wave (Delta) struck Gauteng the hardest, with hospitals battling to cope. KwaZulu-Natal had a less severe wave, but disaster was compounded by the social unrest. The fourth wave (Omicron) started in Gauteng, but

because of its speed of transmission, there was less spatial variability in its patterning. In terms of pandemic management, the earlier institutional architecture remained in place but there was some fine-tuning and improvement in responses. Although the vaccination campaign was driven nationally, there was provincial involvement, and varying provincial capacities made a difference to the rollout, although there were other contextual factors involved.

By August 2022, it was time to take stock of the toll of the pandemic. The South African Medical Research Council indicated that between 3 May 2020 and 13 August 2022 there were an estimated 326 671 excess deaths, or 529 deaths per 100 000 of the population.

ⁱ At the time of this report, the following departments participated in the interviews and informed the data presented in this section: National Department of Health, National Treasury, the National Disaster Management Centre within the department of Cooperative Government and Traditional Affairs (COGTA), the Department of Labour, Department of international relations / foreign affairs (DIRCO), the Department of Sports, Arts and Culture (DSAC), the Department of Land Reform and Rural Development (DLRRD), the Department of Tourism, and the Department of woman, youth and persons with disabilities.