WESTERN CAPE PROVINCIAL PARLIAMENT

AD HOC COMMITTEE ON COVID-19

REPORT OF THE AD HOC COMMITTEE ON COVID-19 ON ITS OVERSIGHT ACTIVITIES UNDERTAKEN DURING THE PERIOD 24 NOVEMBER 2020 TO 30 APRIL 2022

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Report of the Ad hoc Committee on COVID-19, in performing oversight over the work of the provincial executive authority as it responds to the COVID-19 pandemic, including oversight over any part of the provincial executive authority, any provincial department, any organ of state and any provincial entity involved in activities dealing with the pandemic.

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1. Purpose of the Report

The purpose of this report is to report to the House, in compliance with Standing Rule 89(1), on the oversight work of the *Ad hoc* Committee on COVID-19 (the Committee) as assigned to it in terms of Standing Rule 119 and as required of it at its establishment (ATC 14 April 2020 No. 22/2020).

This report includes the establishment of the *Ad hoc* Committee, the details of the exercising of *Ad hoc* Committee's mandate, recommendations and committee decisions from November 2020 to 30 April 2022.

This Report should be read with the Report of the A*d hoc* Committee on Covid-19 on its oversight activities undertaken during the period 24 November 2020 to 30 April 2022 ATC

2. Establishment of the Committee

The Ad hoc Committee on COVID-19 was established by the Speaker of the Western Cape Provincial Parliament (WCPP) on 14 April 2020 in accordance with Standing Rule 119(1) (b) of the Standing Rules of Western Cape Provincial Parliament, ATC 14 April No. 22/2020.

The Ad-hoc Committee was given the assignment to perform oversight over the work of the provincial executive authority as it responds to the COVID-19 pandemic, including oversight over any part of the provincial executive authority, any provincial department, any provincial organ of state and any provincial entity involved in activities dealing with the pandemic.

After consulting all seven (7) political parties represented in the Western Cape Provincial Parliament and all input considered, it was resolved that the Committee shall consist of fifteen (15) Members, as follows:

Members

- Democratic Alliance: Eight (8) Members (Hon R I Allen, Hon D America, Hon D M Baartman, Hon G Bosman, Hon D G Mitchell, Hon W F Philander, Hon A P van der Westhuizen, Hon M M Wenger; Alternates: Hon L J Botha, Hon R D MacKenzie, Hon L M Maseko).
- African National Congress: Three (3) Members, but elected not to participate.
- Economic Freedom Fighters: One (1) Member (Hon M Xego).
- Other smaller opposition parties: Three (3) Members jointly (Hon B N Herron [GOOD], Hon F C Christians [African Christian Democratic Party], Hon P J Marais [Freedom Front Plus], Al Jama-ah elected not to participate).

On 16 April 2020 (ATC No. 23/2020) the Committee membership was amended to include Members of the African National Congress as follows:

- African National Congress: Three (3) Members, (Hon C M Dugmore, Hon P Z Lekker, Hon R Windvogel; Alternates: Hon N G Nkondlo, Hon M K Sayed, Hon D Smith).

On 25 May 2021 (ATC 52/2021) the Ad-hoc Committee on COVID-19 membership was amended with changes to the membership of the Democratic Alliance as follows:

- Hon L J Botha was added as a permanent committee member and Hon DG Mitchell was removed as a committee member.

On 15 March 2022 (ATC No. 26/2922) the Committee membership was amended to include a Member of the Good Party:

- Good Party: Hon B Herron was removed and Hon S N August was included.

Procedural Staff:

- Ms Z Adams, Procedural Officer
- Ms L Cloete, Senior Procedural Officer

Procedural Staff amended in January 2021:

- Ms W Hassen-Moosa, Procedural Officer
- Ms S Jones, Procedural Officer
- Mr B Daza, Senior Procedural Officer
- Ms MA Burgess, Committee Assistant

The Committee had all the general powers conferred upon committees in accordance with the Standing Rules (Rule 91), as well as any other powers, where applicable, conferred upon committees generally in accordance with the Standing Rules (Rules 77–95). (ATCs included in Annexure A)

The Committee was requested to meet by way of electronic means until such time as the spread of the virus has been adequately contained so as to render in-person meetings safe. All meetings have been held virtually, so as to comply with COVID-19 lockdown regulations issued by the National Government, as well as a decision of the WCPP Programming Authority, to enforce social distancing rules. The Committee was instructed to report regularly on its findings. The Committee has tabled 11 reports, as follows:

ATC 106, 30 November 2020, Report 08/2020 - November 2020
ATC 17, 23 February 2021, Report 09/2020 – December 2020 activities
ATC 36, 09 April 2021, Report 10/2021 – January 2021 activities
ATC 36, 09 April 2021, Report 11/2021 – February 2021 activities
ATC 83, 05 August 2021, Report 12/2021 – March 2021 activities
ATC 83, 05 August 2021, Report 13/2021 – May 2021 activities
ATC 83, 05 August 2021, Report 14/2021 – June 2021 activities
ATC 115, 13 October 2021, Report 15/2021 – July 2021 activities
ATC, 140, 07 December 2021, Report 16/2021 – August 2021 activities
ATC, 140 07 December 2021, Report 17/2021 – September 2021 activities
ATC 41, 14 April 2022, Report 18/2021 – December 2021 activities
ATC ……, Report 19/2022 – March 2022 activities

2.1 Adopted Themes

On 17 April 2020, the Committee adopted 12 themes around which it would conduct its oversight work over government response to the COVID-19 pandemic. During the period under review, the following themes were covered:

1. Health Department Responses and Preparations
2. Protection of the Vulnerable
3. Disaster Management and Local Government Oversight
4. Economic Recovery, Support and Livelihoods
5. Transport and Infrastructure
6. Schooling and Education
7. Intergovernmental Relations and Community Cooperation
8. Government Finance and Budgets

2.2 Rules of Engagement

Rules of Engagement during virtual meetings were indicated as follows:

1. All meetings would be open to members of the public and media via livestreaming;
2. All Members microphones must be muted at the beginning of the meeting to avoid background noise;

3. Members are to flag Points of Order in the Chat Function of Microsoft Teams (the application through which virtual meetings are held);
4. All videos and audio must be switched off to improve the quality of the connection; however, if a Member/Minister/HOD/Official is speaking, they may put on their audio and video;
5. Participants must switch off their microphones once they are finished speaking;
6. Section 10 of the Directives ATC'd on 17 April 2020 speaks to the application of Standing Rules. Section 10 states that "in instances where these directives are not clear or do not cover a particular eventuality in respect of sittings of the House or meetings of the committees by means of videoconferencing, the Standing Rules must apply as far as this is reasonably and practically possible and, in instances where they cannot be applied, the ruling by the presiding officer must be final".

3. Context and trajectory of the COVID-19 virus in the Western Cape

Four COVID-19 waves (i.e. surges in new cases followed by declines) have been experienced in the Western Cape to date, as depicted in Figure 1. This figure shows several key metrics used to track the COVID-19 epidemic in the province including cases, hospital admissions, deaths, oxygen supplied to hospitals, and test positivity rate.

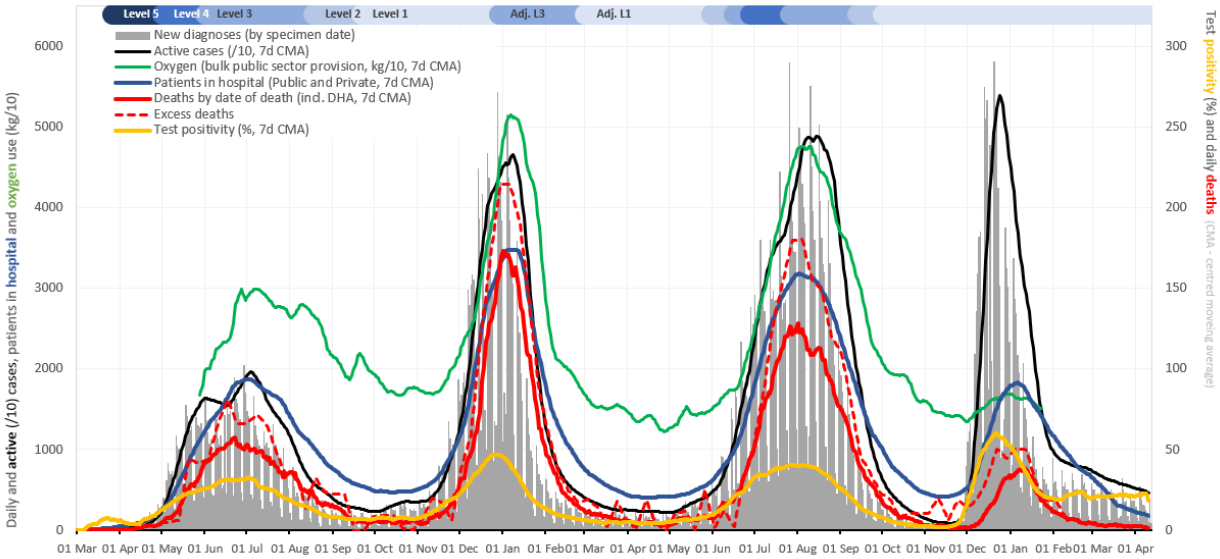

Figure 1: Western Cape COVID-19 Epidemic (to 13 April 2022)

[1] Wave dates determined based on National Institute for Communicable Diseases (NICD) wave definition, that is, the period from when COVID-19 weekly incidence is equal to or greater than 30 cases per 100 000 persons until the weekly incidence is equal to or below 30 cases per 100 000 persons.

3.1. Current Epidemic Status

Table 1: Summary of Current Epidemic Status in the Western Cape (as of 18 April 2022)

Key COVID-19 Indicator	Total No.
Confirmed COVID-19 infections	675,392
Individuals infected with COVID-19	660,029
Reinfections	15,363
Tests Done (PCR and Antigen)	3,095,198
COVID-19 related deaths	21,915

3.2. Cases

There is considerable variation in the epidemic curves of the COVID-19 waves (Figure 4) between the six districts in the province. For example, the rural Western Cape districts all experienced a more protracted third wave compared to the first and second waves. In the Cape Metro district, Khayelitsha had a significantly smaller third wave compared to the other sub districts, likely due to protection conferred by higher seroprevalence in the community by the end of the first and second waves. The fourth wave in both rural and Cape Metro districts peaked much sooner (i.e. had a more rapid rise in cases) than the first three waves.

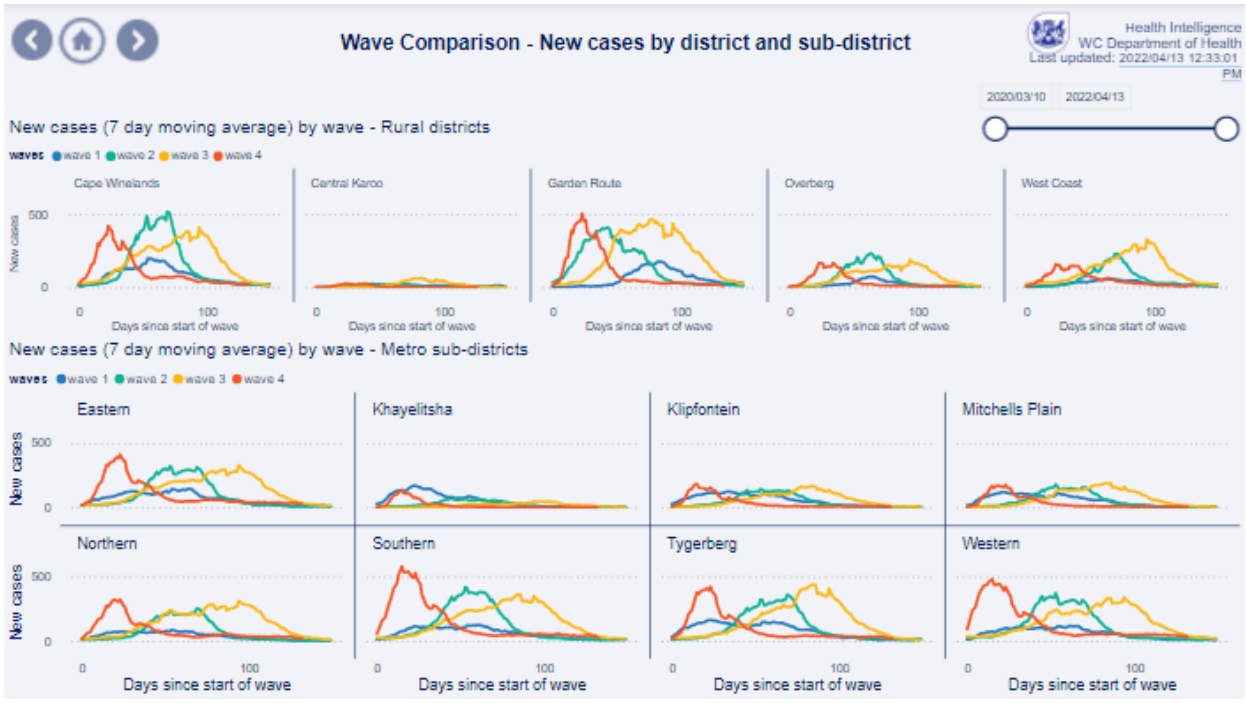

Figure 4: Comparison of first three waves superimposed, by district and subdistrict

[2] Wolter N, Jassat W, Walaza S, Welch R, Moultrie H, Groome M, Amoako DG, Everatt J, Bhiman JN, Scheepers C, Tebeila N. Early assessment of the clinical severity of the SARS-CoV-2 omicron variant in South Africa: a data linkage study. The Lancet. 2022 Jan 19. DOI: https://doi.org/10.1016/S0140-6736(22)00017-4.

[3] Maslo C, Friedland R, Toubkin M, Laubscher A, Akaloo T, Kama B. Characteristics and outcomes of hospitalized patients in South Africa during the COVID-19 Omicron wave compared with previous waves. Jama. 2022 Feb 8;327(6):583-4. https://doi.org/doi:10.1001/jama.2021.24868.

3.3 The summary of COVID-19 waves

Table 2: Western Cape COVID-19 estimated wave periods

Wave	Duration	Time period
Wave 1	106 days	3 May – 16 August 2020 *Peak: 28 June 2020*
Wave 2	92 days	8 November 2020 – 7 February 2021 *Peak: 3 January 2021*
Wave 3	120 days	23 May – 19 September 2021 *Peak: 1 August 2021*
Wave 4	64 days	28 November 2021 – 30 January 2022 *Peak: 19 December 2021*

Table 3: Cases, admissions and deaths in each COVID-19 wave in the Western Cape (in total and at wave peak)

	Total			7-day moving average at wave peak		
	Cases	Admissions	Deaths	Cases	Admissions	Deaths
Wave 1	93,373	13,958	3,582	1,260	190	47
Wave 2	149,736	21,208	6,357	3,180	456	144
Wave 3	220,290	24,181	7,878	3,226	341	116
Wave 4	120,508	9,019	1,279	3,660	159	12

3.4. Testing

Figure 2 shows the number of SARS-CoV-2 tests conducted across both the public and private sector from 1 November 2020 to 8 April 2022. It should be noted that the number of tests and proportion of positive tests is influenced by a number of factors as follows:

- Restricted public sector testing during wave surges and continued after the end of the 4th wave such that testing was restricted to those requiring hospital admission, older patients (>40, 45 or 50 years depending on wave) and/or with comorbidities and health care workers.
- Availability and expansion of antigen testing from ~December 2020 onwards.
- Incomplete reporting of antigen tests especially limited reported of negative antigen tests from late 2021 onwards when reporting of negative antigen tests was no longer required.

In addition to the overall proportion positive shown in figure 1, we have therefore shown the proportion positive for PCR tests only as this metric is not affected by lack of reporting of negative antigen tests (Figure 3).

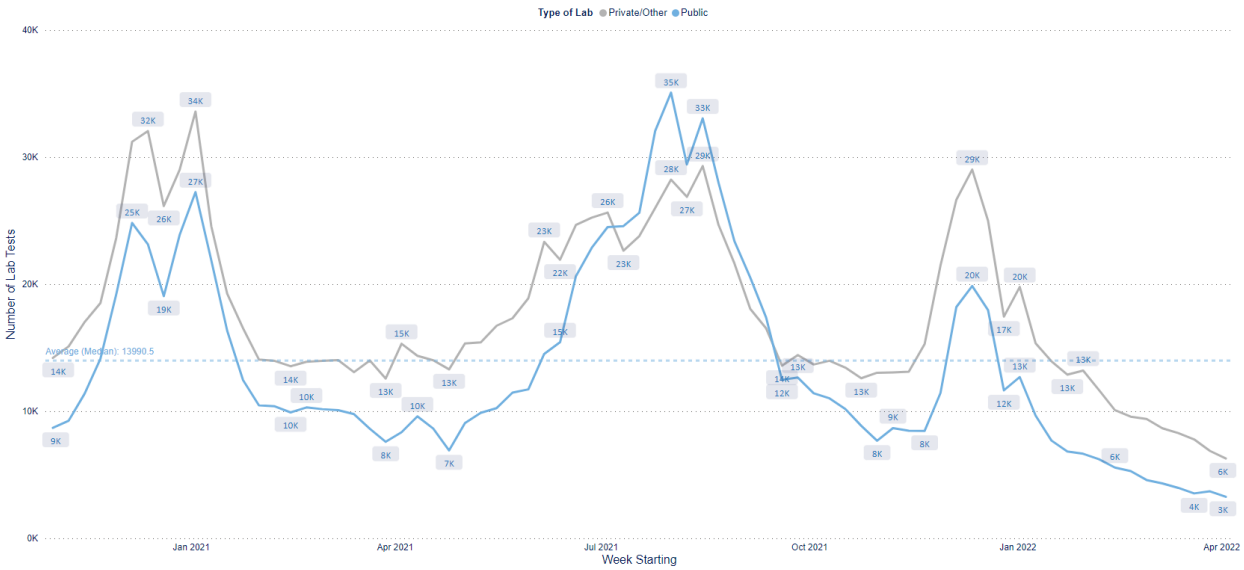

Figure 2: Weekly number of tests for SARS-CoV-2 conducted in the Western Cape by sector (public and private).

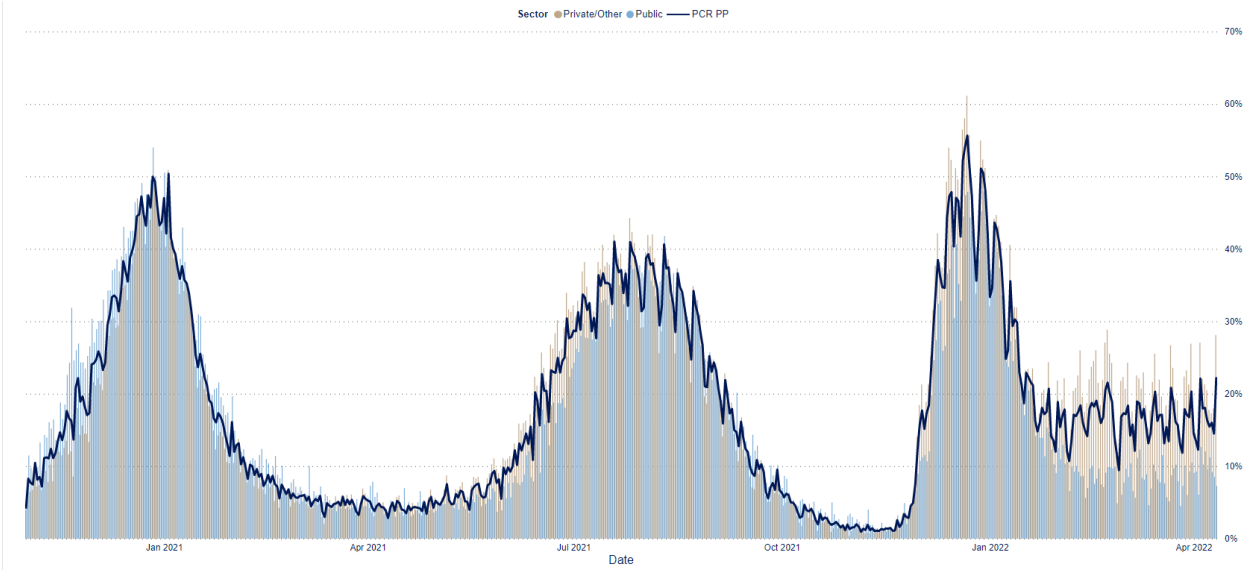

Figure 3: Proportion of positive SARS-CoV-2 PCR tests conducted in the Western Cape from 1 November 2020 to 14 April 2022

3.5. Hospitalisations

Both the metro and rural districts experienced fewer peak daily new hospitalisations during the third wave compared to the second but experienced high admission pressure over a longer period of time than in the first two waves (Figure 5). Rural districts varied in their experience of hospital admission numbers, with Garden Route and West Coast seeing more new admissions in the third wave than the first two waves.

The fourth wave peak of admissions was lower than the second and third waves in the Cape Metro and across most rural districts, despite a higher peak case load in the province. Analyses of national COVID-19 case data, SARS-CoV-2 laboratory test data, SARS-CoV-2 genome data, and COVID-19 hospital admissions data found that individuals infected with the Omicron variant had a significantly reduced odds of severe disease compared to individuals infected with the Delta variant.[2] In addition, an analysis of Netcare hospital data found that a lower proportion of COVID-19 patients presenting to emergency centres were admitted in the fourth wave compared to the first three waves, the proportion of patients requiring oxygen therapy or ventilation significantly decreased, and the medium length of stay decreased to 3 days from 7-8 days.

This reduced severity of COVID-19 in the fourth wave was found to be mostly due to protection from prior immunity or vaccination, but also partially due to the intrinsically reduced virulence of the Omicron variant compared to the Delta variant.4 Thus, in the fourth wave where Omicron was dominant, hospital admissions were "decoupled" from infections.5

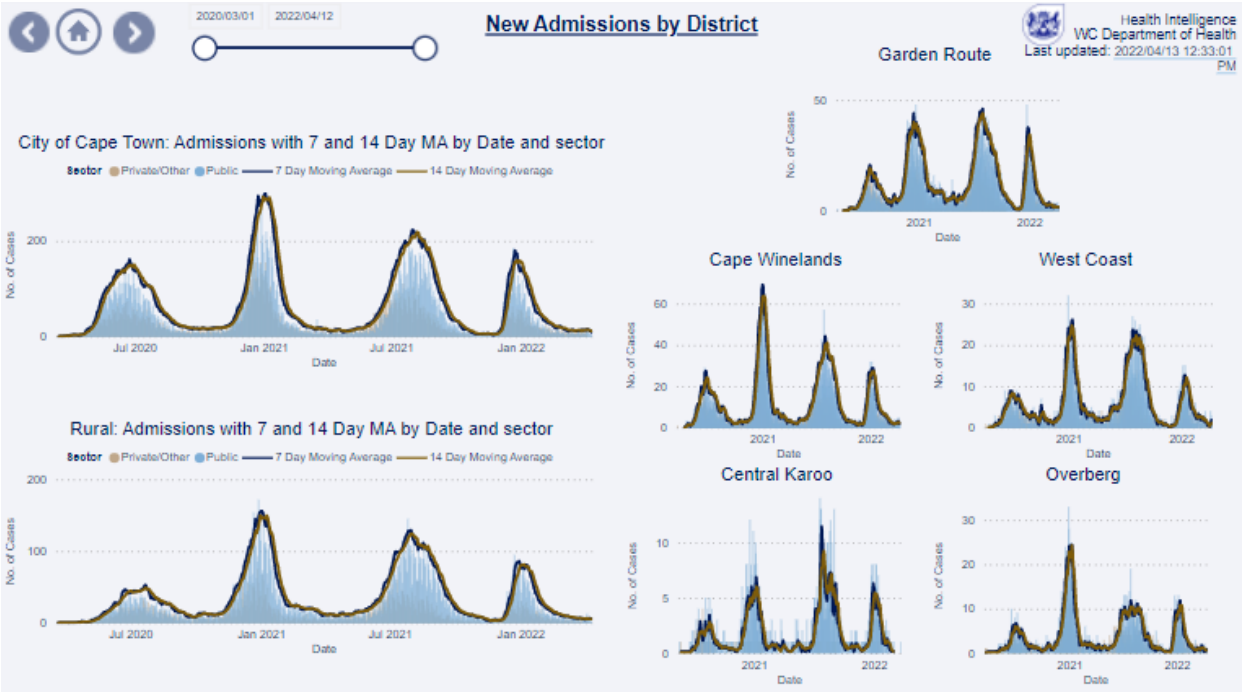

Figure 5: Western Cape hospitalisations due to COVID-19 (7- and 14-day moving averages)

3.6. Deaths

The South Africa Medical Research Council (SA-MRC) have been reporting on excess mortality (due to natural causes of death), and for the Western Cape, have reported 31,100 excess deaths between 3 May 2020 and 9 April 2022. The SA-MRC estimates that 85-95% of excess natural deaths can be attributed to COVID-19, although this does differ per province.7 A comparison of the reported COVID-19 deaths and excess natural deaths for the Western Cape can be seen in Figure 6.

Since then, in early October, the testing criteria was expanded so that anyone in the province experiencing COVID-19 symptoms can be tested, as well as pre-operative testing for coronavirus asymptomatic patients, natural deaths occurring at home in persons who had coronavirus symptoms, Health Care.

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4 Davies MA, Kassanjee R, Rousseau P, Morden E, Johnson L, Solomon W, Hsiao NY, Hussey H, Meintjes G, Paleker M, Jacobs T. Outcomes of laboratory-confirmed SARS-CoV-2 infection in the Omicron-driven fourth wave compared with previous waves in the Western Cape Province, South Africa. medRxiv. 2022 Jan 1. DOI: https://doi.org/10.1101/2022.01.12.22269148.

5 Madhi SA, Kwatra G, Myers JE, Jassat W, Dhar N, Mukendi CK, Nana AJ, Blumberg L, Welch R, Ngorima-Mabhena N, Mutevedzi PC. Population immunity and Covid-19 severity with Omicron variant in South Africa. New England Journal of Medicine. 2022 Feb 23. DOI: https://doi.org/10.1056/NEJMoa2119658.

6 https://www.samrc.ac.za/sites/default/files/files/2022-04-13/weekly9Apr2022.pdf

7 https://www.samrc.ac.za/sites/default/files/files/2021-03-03/CorrelationExcessDeaths.pdf

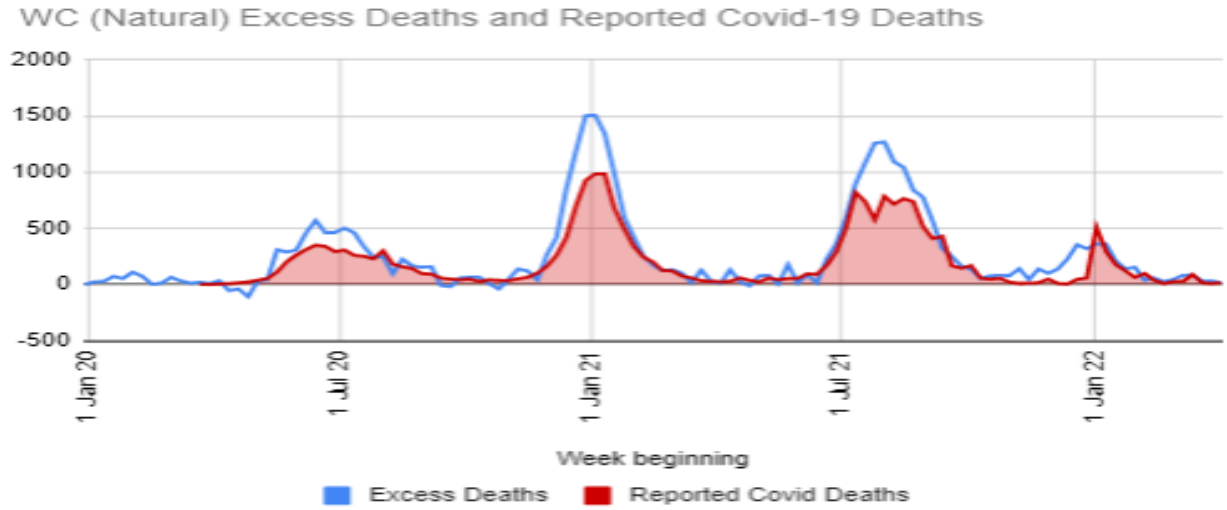


Figure 6: Western Cape excess mortality (SA-MRC) through to 9 April 2022

Although there were more deaths in Wave 3 overall because of the protracted nature of the wave, the second wave had the highest peak of daily deaths (Figure 7). The reduced severity of Wave 4, and thus the decoupling of COVID-19 infections from deaths is seen even more clearly in the deaths data than it was in the hospitalisation data, as there was a much lower peak of COVID-19 deaths (and far fewer deaths overall) than in the preceding waves. There were also likely to be more deaths reported as "COVID-19 deaths" where COVID-19 was incidental, rather than the primary cause of death, in the fourth wave compared to previous waves.

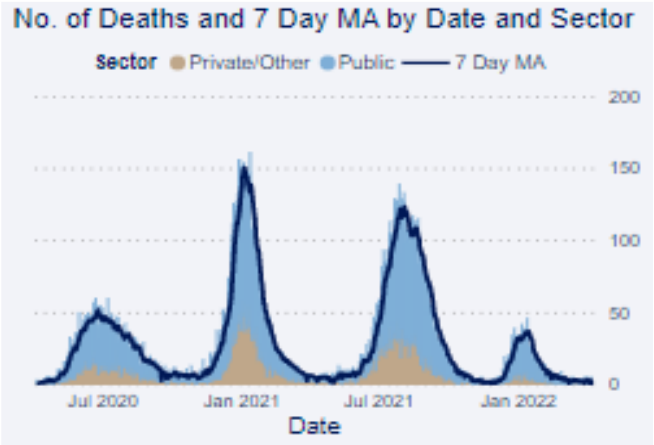
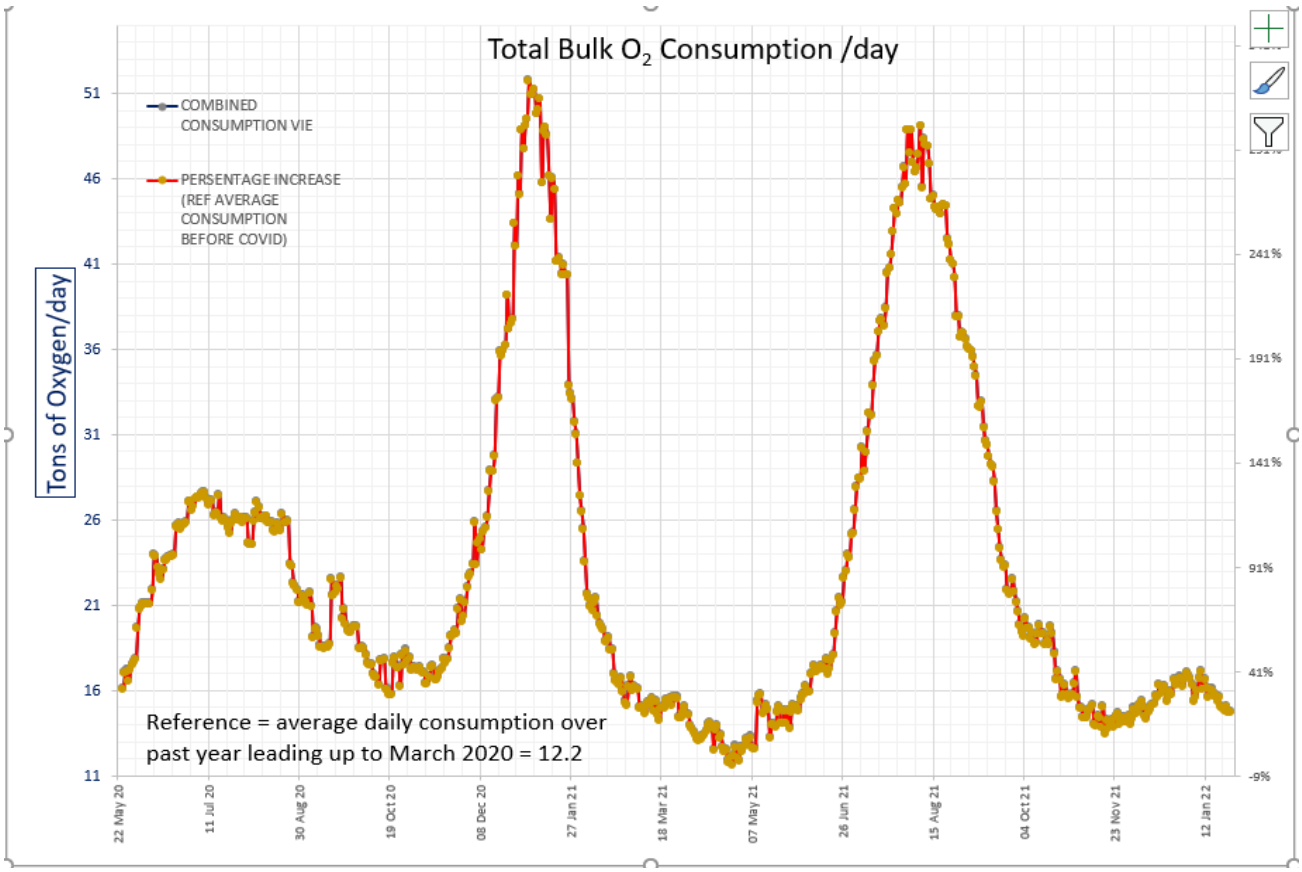


Figure 7: Western Cape deaths due to COVID-19 (7-day moving average)

8 Paleker M, Ann Davies M, Raubenheimer P, Naude J, Boulle A, Hussey H. Change in profile of COVID-19 deaths in Western Cape Province, South Africa, during the fourth wave. SAMJ: South African Medical Journal. 2022 Mar;112(3):0-. DOI: http://dx.doi.org/10.7196/SAMJ.2022.v112i2.16384.

3.7. Oxygen supply



The diagram above indicates oxygen utilisation during the 4 COVID-19 waves in the Western Cape. The Department of Health routinely collects data on oxygen utilisation, but it was during the COVID-19 outbreak that we realised the close relationship between oxygen utilisation and state of the outbreak. High flow nasal oxygen is used extensively in the treatment of patients with moderate or severe COVID-19, particularly those requiring admission to hospital. Consequently, as COVID-19 admissions increase, so too does oxygen utilisation with the effect that the oxygen utilisation pattern follows the same pattern as the COVID-19 infections. The second COVID-19 wave saw the peak utilisation of oxygen. Wave 4 saw the lowest oxygen utilisation of all the waves.

3.8. Vaccines

Vaccines became available in South Africa in early 2021, and which were introduced in a staged approach. The first to be vaccinated were health care workers in the Sisonke Trial. Later, vaccines were administered by age cohorts. As vaccines were approved by SAHPRA and availability improved, additional doses became available.

COVID-19 vaccinations as on 25 April 2022

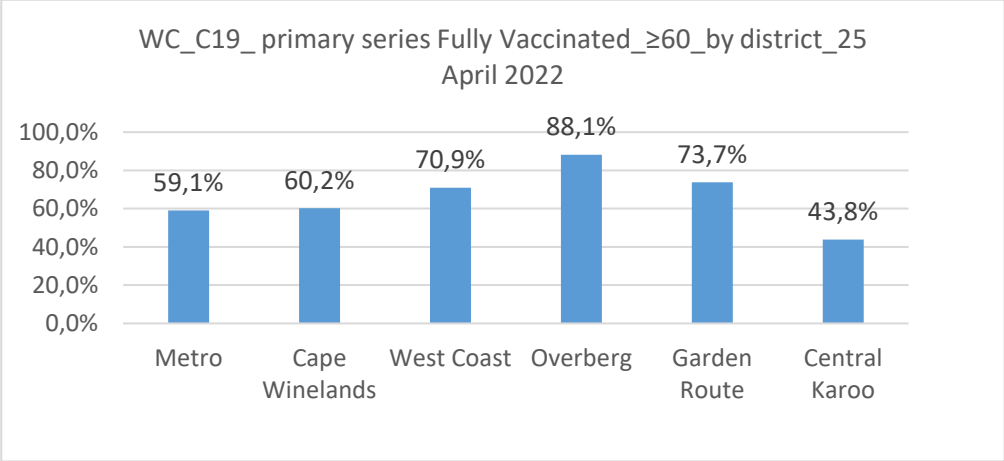
In the Western Cape, 2 550 270 adults have been fully vaccinated accounting for 51.24% of adult population. To date in the Western Cape 5 340 694 vaccines have been administered.

COVID-19 individual adults' primary series fully vaccinated as on 25 April 2022:

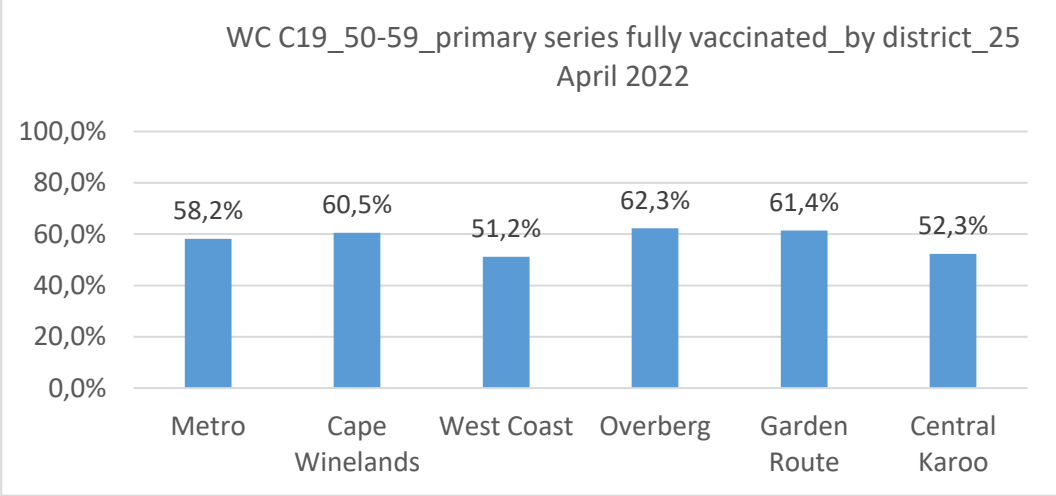
- Western Cape adults fully vaccinated age cohort 60+ - **70.81%**
- Western Cape adults fully vaccinated age cohort 50-59 - **61.93%**

- Western Cape adults fully vaccinated age cohort 35-49 - **53.54%**
- Western Cape adults fully vaccinated age cohort 18-34 - **39.12%**

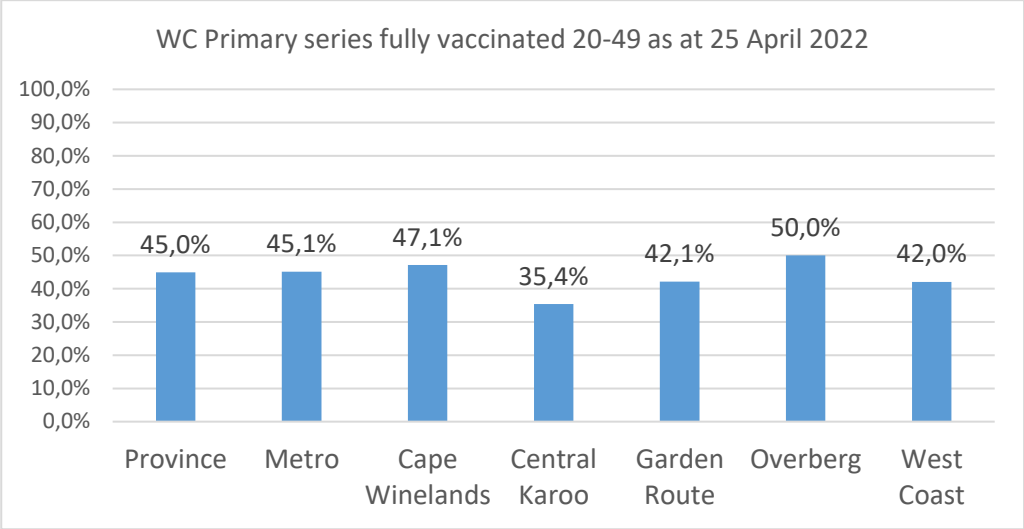
Primary series fully vaccinated for the ≥60 cohort at district level_ 25 April 2022



Primary series fully vaccinated for the 50-59 cohort at district level_ 25 April 2022



Western Cape primary series fully vaccinated in the 20-49 cohort by district – 25 April 2022



The Western Cape currently has 7685 active COVID-19 cases in the province on 3 May 2022.

On 4 April 2022, the National State of Disaster was lifted.

4. Health Department Responses and Preparations

4.1. 28 December 2020: Briefing by the Premier of the Western Cape and the Provincial Minister of Health on the COVID-19 pandemic, in light of the resurgence/second wave of the COVID-19 virus. The update by the Premier of the Western Cape and the Director-General of the Department of the Premier on the 'adjusted' Alert Level 3 lockdown. The update by the Provincial Minister of Health and the Head of the Provincial Department of Health on the situational analysis of the pandemic in the Province.

In late December of 2020, during the parliamentary recess period, it became clear that a second wave had hit the Western Cape. Hospitalisations and deaths in the province were increasing rapidly. Hospital capacity and oxygen availability was a concern. For this reason, the Chairperson of the Committee, Ms Mireille Wenger, requested permission from the Speaker of the WCPP in terms of Standing Rule 87(2) to meet during the recess period. Permission was granted and the Committee convened virtually on 28 December 2020. The Premier and the Minister of Health were requested to brief the committee.

The Premier, Mr Alan Winde, informed the Committee that the Province submitted a COVID-19 resurgence plan for the Western Cape to the President of South Africa on 4 December 2020, to enable the National Command Council to deliberate on the input of the Western Cape.
The President adopted a differentiated approach and declared the Garden Route a hotspot on 14 December 2020 and consequently closed all beaches and parks since an increase in infections was experienced in most municipalities in the Western Cape at the time. On 28 December 2020 the President declared the whole of the Western Cape a hotspot.
The Premier's Coordinating Forum (PCF) management system was established for the Province. The PCF's overall objective was for political and administrative leadership to engage in order to address matters of interest to the communities of the Western Cape.
The Department of the Premier continued to engage with Minister Mbombo, the entire health team as well as the advisors and epidemiologists to try to build a revised model since the Province was informed that a different strain of the COVID-19 virus had been detected. The teams then had to understand the implications of this new strain for the current model of the Province.
Regular meetings with Faith-based Organisations (FBOs) arranged by Ministers Meyer, Fernandez and Marais, continued to address the issues of reducing crowds and gatherings, which the FBOs agreed to. The Premier met with the agricultural sector as well to address the movement of seasonal workers, which posed a challenge as well to curb the movement of persons.
The Premier informed the Committee that as at Monday, 28 December 2020, the cumulative number of confirmed cases of COVID-19 in the Western Cape was 196 474. The total number of COVID-19 related deaths was 6 332, and there were 151 261 recoveries. 1 005 085 tests had been completed and there were 3 064 hospitalisations with 363 of these cases in the Intensive Care Unit (ICU) or high care.

Health Update:

Dr Cloete further briefed the Committee on the 5-point COVID Resurgence Strategy, which translated into the 5-point COVID Containment Strategy, focusing on the following:

- Changing community behaviour to prevent infection;
- Surveillance and outbreak response;
- Scaling up the health platform COVID capacity;
- Maintaining comprehensive services; and
- Safeguarding and protecting the well-being of health care workers.

The Province, as a whole, continued to see substantial increases in daily new cases, which were 2.4 times higher than in the peak during the first wave, despite limited testing due to public holidays and restricted testing criteria.
Hospitalisations and deaths continued to increase sharply. New hospital admissions were 50% higher and the number of deaths were 22% higher than the first wave.
With reference to the Resurgence in the different areas, the Metro continued to see steep increases in cases with nearly a double the amount of new daily cases compared to the first wave peak. Rural districts had nearly 2.5 times more cases in December 2020 than in the peak of the first wave. In respect of rural districts, the second wave peak had more than double the amount of cases than the Province had in the first wave peak, except for Central Karoo, which showed a 64% increase in cases compared with the first wave peak. The Garden Route continued to show a stabilising pattern but this was being monitored closely given the large numbers of visitors to the district.
As at 29 December 2020, 3 131 COVID-19 patients were in acute Western Cape hospitals where 1 885 patients were in public hospitals and 1 246 patients were in private hospitals. Metro hospitals had an average occupancy of 103%, George hospitals were at 90% capacity, Paarl hospitals were at 101% capacity and Worcester was at 94% capacity.
The Primary Health Care (PHC) facilities were facing an increasing demand for COVID-19 testing and provided triaging for confirmed cases.
Hospital capacity at the time had 7 464 acute operational public sector beds, which excluded beds at psychiatric hospitals, Tuberculosis (TB) hospitals, Red Cross hospitals and Mowbray Maternity hospital, but was inclusive of 135 critical care public sector beds for COVID-19 patients.
613 Additional field hospital beds were made available in the Metro, 336 beds in Brackengate and 90 at Lentegeur, as well as an additional 187 intensive care beds at Lentegeur and 59 intermediate care beds at Sonstraal. Depending upon staff availability and if the needs existed, an additional 136 intermediate care beds would be made available across the metro and rural regions.
The Hospital of Hope (Brackengate), at the time, had 299 patients, and Sonstraal had 20 COVID-19 patients and 27 TB patients.
The mass fatality centre in the Metro had the capacity to hold 240 bodies. The mass fatality centre admitted 106 bodies. The Province had a Mass Fatality Work Group that coordinated in respect of capacity across the Province.
Oxygen utilisation was running at 68.92% of the available daily capacity.
Temporary tents were commissioned at Khayelitsha and Wesfleur Hospitals and would be ready for use from 30 December 2020 for admissions and discharges, which in turn would create additional capacity. Tents were going to be erected at Mitchells Plain Hospital and Brackengate by 31 December 2020, as well as at Eerste River, Helderberg and Karl Bremer hospitals, which would be ready by 8 January 2021.
The biggest challenge that remained was the impact of alcohol-related trauma on the health facilities, especially in emergency centres and in critical care units.
A daily oxygen need and oxygen utilisation dashboard had been established to monitor demand versus supply across all hospitals. The hospitals with the highest oxygen availability and utilisation pressures were Worcester, Mitchells Plain, Karl Bremer and Victoria hospitals.
AFROX was producing 65 tons of oxygen per day and the Province was using 52 tons of oxygen per day. AFROX agreed to make an additional five tons of oxygen per day available to hospitals.
The biggest challenge in the health sector was the increasing COVID-19 infection rate amongst health care workers and the impact on staff members in respect of isolation and quarantine. Additionally, the availability of additional staff members for contract work and via agencies posed a significant challenge. The number of persons volunteering their services also decreased significantly.
As at 29 December 2020, 926 Health Care Workers across 92 institutions were infected with COVID-19, which equates to 2.8% of the total staff complement of 33 062. A cumulative total of 7 215 staff members took COVID-19 related leave since March 2020.

There was sufficient Personal Protective Equipment Clothing (PPE) across all the health facilities, and in central storage, with additional orders being placed.
The Department scaled up its system of on-site support for frontline staff in respect of mental health and well-being.
A pro-active strategy had been embarked upon to access the South African Health Products Regulatory Authority (SAHPRA) approved vaccines in the Western Cape and the National Minister of Health had been officially engaged on this matter. Technical experts were going to conduct a formal option appraisal of all available candidate vaccines in terms of efficacy, safety, affordability etc.
Prioritisation in the administering of the vaccine was going to be given to Health Care Workers and other essential workers, then vulnerable groups such as elderly persons and persons with co-morbidities.
The timelines provided and way forward regarding the vaccine included SAHPRA approval and the sourcing and distribution strategy to provide vaccines in early 2021.

Governance arrangements, Law Enforcement, Communications response and Fatalities Management:

Dr Malila informed the Committee that the Premier convened a weekly strategy meeting and the PCF meetings were held weekly over the holiday period.
The Provincial Disaster Management Committee (PDMC) remained activated for the COVID-19 pandemic and was monitoring the second wave. The PDMC Joint Operations Committee (JOC) briefing meetings took place every Tuesday.
Western Cape Provincial Traffic Services implemented a total of 274 integrated roadblocks, vehicle check points and speed control operations during the period of 21 to 27 December 2020, and 22 685 vehicles were checked.
There have been 320 investigations into contraventions of the National Disaster Management Regulations since 27 March 2020. Of these 320 matters, 91 Section 71 matters were placed on the Liquor Licensing Tribunal case roll, of which 53 licenses were suspended.
The Western Cape Government ran extensive communication campaigns in all languages, using a variety of different media channels so that all communities were able to get the messages needed to stay safe. This was in addition to daily media statements, and the Premier's weekly DigiCons.
The City of Cape Town and all five districts revisited their Mass Fatality Plans and associated support plans with a view to ensure their readiness for implementation on short notice. All plans were shared with the District JOC and Joint District and Metro Approach (JDMA) structures.

4.2. 13 January 2021: Briefing by the Western Cape Department of Health on the situational analysis of the pandemic in the Province in the light of the aggressive resurgence of the COVID-19 virus in the Western Cape Province, including information with respect to the latest figures and expected peak in the Province, oxygen management, hospital capacity, fatality and mortuary management, and vaccine roll-out readiness for the Province

Dr Cloete explained that there was a Five-Point COVID-19 Containment Strategy for the Province. The first point consisted of changing community behaviour to prevent infection, the second point focused on surveillance and outbreak response, the third point looked at scaling up the health platform capacity, the fourth point focused on maintaining comprehensive services, and the fifth point was about safeguarding and protecting the well-being of healthcare workers.

As at 13 January 2021, there was a decline in the amount of COVID-19 tests that had a positive result. Both private sector and public sector hospitals were full but there was a decrease in the number of COVID-19 patients being admitted on a daily basis. The critical care units in public and private hospitals were under pressure because these facilities were at full capacity.

The “reproduction number” measured how many other persons an active COVID-19 positive person had infected. At the acceleration of the first peak in July 2020, every COVID-19 positive case was infecting approximately 1.32 other COVID-19 cases. In early December 2020, one case was infecting close to 1.6 cases, which meant that every 10 cases was infecting 16 other cases. This was attributed to the second variant of the COVID-19 virus that was more infectious. As at 13 January 2021, it seemed as if the Province was stabilising i.e. every one case was infecting one other case. If the reproduction number dropped below one, then the Province would see a decline in cases.

As at 13 January 2021, there were 3 323 COVID-19 patients in the Province’s acute hospitals (1 889 in public hospitals and 1 434 in private hospitals). COVID-19 hospitalisations seemed to have stabilised, however, psychiatric pressures remained. The Metro hospitals had an average occupancy rate of 93%, the George drainage areas hospitals were at 61% capacity, Paarl drainage area hospitals were at 74% capacity, and the Worcester drainage area hospitals were at 73% capacity.

Deaths due to COVID-19 continued to increase. There was also a delay in reporting of deaths, therefore, the number of deaths was expected to increase as more information was still forthcoming.

In terms of the health platform capacity, Dr Cloete stated that the Primary Health Care (PHC) facilities continued to undertake COVID-19 testing and triaging cases. There had also been an active de-escalation of non-COVID-19 PHC services, however, the delivery of medicines to homes continued. At 13 January 2021, there were a total of 7 693 acute operational public sector beds, 626 intermediate care beds in the Metro (336 at Brackengate, 90 at Lentegeur, and 200 at Mitchell’s Plain Hospital of Hope), 64 intermediate care beds at Sonstraal Hospital, and 20 of the potentially additional 136 intermediate care beds were opened.

Temporary tents were commissioned at Khayelitsha, Wesfleur, Mitchell’s Plain, Eerste River, Helderberg, Karl Bremmer and Brackengate. These were used for discharges, mainly to ensure a more rapid turnaround time of the operational beds.

As at 13 January 2021, provincial oxygen consumption was at 69.57% of total capacity. The combined oxygen utilisation in the Western Cape public and private hospital sectors, at the time, was approximately 73 tons daily. This was a slight reduction from the average daily utilisation the previous week. Prior to the pandemic, the average daily oxygen consumption (leading up to March 2020) was 12.2 tons per day. At the peak of the first wave of the pandemic, average oxygen consumption was approximately 27 tons per day. This settled to approximately 17 tons per day post the first peak. At 13 January 2021, the average oxygen consumption was 73 tons per day (48 tons per day in the public sector and 25 tons per day in the private sector).

While the public sector hospital consumption of oxygen was at 61% of the Province’s production capacity, the additional 31% was used by the private sector. The combined utilisation was above the maximal production capacity of the Afrox Western Cape plant. However, Afrox had put contingency plans in place by bringing additional oxygen into the Province, daily. The utilisation of oxygen was going to be monitored carefully over the next few weeks.

A working group was established to plan for and put measures in place, across the Province, to cope with mass fatalities, should the need arise. The working group developed a strategy for fatality management at provincial and district level, which included mass fatality plans and supporting strategies, communication protocols, and mass burial capabilities, should this be required. The Department of Home Affairs was also supported with the opening of additional offices and the extension of working hours over the festive season so that deaths could be registered more efficiently. In terms of crematoria, facilities were requested to function during the night and over the weekends in order clear the backlogs.

In terms of the vaccine strategy, the National Department of Health was driving the procurement process and the Provincial Department of Health was aligned with their efforts. On 7 January 2021, the National Minister of Health, Dr Zweli Mkhize, announced that that one million doses of

the Astra Zeneca vaccine would be acquired from the Serum Institute of India at the end of January 2021, and a further 500 000 doses would be acquired in February 2021. Further negotiations were being pursued with other vaccine suppliers for more stock to be secured via the COVID-19 Vaccines Global Access (COVAX) initiative. The Provincial Department of Health's focus was on the readiness to implement the vaccine programme in the Province.

The objective of the vaccine programme was to provide equitable and ethical access to COVID-19 vaccines in the Western Cape to reduce morbidity and mortality in vulnerable persons, reduce community transmission through herd immunity, and to protect the health system capability. Phase I of the vaccine programme would focus on the roll out of the vaccine to health care workers in the public and private sectors, care workers, Community Health Workers and health science students. The estimated target for this phase was 100 000 persons. Phase II would focus on essential workers, clients in congregate settings, persons older than 60 years, and persons older than 18 years with known comorbidities. Phase III would focus on all persons older than 18 years. This strategy would be further refined based on expert advice.

Dr Cloete warned that the vaccinations did not replace the need for non-pharmaceutical interventions such as mask wearing, social distancing and hand washing, for the foreseeable future. The Department's biggest concern was the non-adherence to protective behaviours. The key consideration was that health care workers continued to face significant strain, and that they needed to be safe-guarded. It was essential to maintain a strong focus on behaviour change to ensure containment of the virus over the next six months, while clarity around the vaccine was still emerging

4.3. 03 February 2021: Briefing by the Western Cape Department of Health on the COVID-19 virus development and indicators, as well as vaccine planning, focusing on the following: The receipt of the vaccine in all phases; The numbers and types of vaccines expected for the Province; The roll out planning of the vaccine; and the possibility of a generic vaccine being developed and whether the country would be able to acquire it (stand-over question from previous meeting)

The Minister of Health, Dr N Mbombo, informed the Committee that the briefing would cover the receipt of the vaccines in all phases, the vaccine roll out planning, the possibility of new vaccines that were being developed, the acquisition of vaccines, as well as the roll out prioritisation. One million vaccine doses had already arrived and a further 500,000 would be arriving at the end of March 2021. Those doses were purchased by the national Department of Health and National Treasury from the Serum Institute of India and Oxford University which is better known as "COVISHIELD" by their developers that would be utilised in the first phase.

The Phase I of the vaccine roll out would be primarily targeting healthcare workers in both the public and private sectors—those on the Personnel and Salary Administration System (PERSAL) employed by provinces; those who were not on PERSAL but were working for the Department of Health in the public sector; as well as workers appointed by the City of Cape Town. The Minister stated that nursing students fell under part of the "other" category with community care workers and traditional health practitioners.

Minister Mbombo, informed the Committee that the vaccines consisted of two doses. Currently there are 702 000 health workers in South Africa of which 133 000 are in the Western Cape. These figures assisted in determining the total number of doses needed for the first phase.

Minister Mbombo noted that a vaccine reduces the chances of infection, transmission and death. Thus, it protects the health system overall. She urged everyone to adhere to health protocols and discouraged people from attending huge gatherings such as churches and restaurants.

Health update

Dr Cloete provided the Committee with an update on the COVID-19 virus development and indicators, as well as vaccine planning.

Dr Keith Cloete informed the Committee that the province had already passed the peak of the second wave and showed a decline in the number of daily infected cases. Places like Caledon had almost no active coronavirus cases and the Garden Route was also showing a declining trend.

Various data was presented to show the province's COVID-19 response. These included hospital admissions by area (currently 2 330 COVID-19 patients in acute hospitals) (1 398 in public hospitals and 932 in private hospitals), and utilisation per drainage area, and the total bulk oxygen consumption had been reduced to around 31.41 tons daily when compared to 51 tons daily in the first week of January.

Dr Cloete outlined the Department's plan to assist and safe-guard the wellbeing of healthcare workers.

The detailed vaccine implementation plan was provided to the Committee. Dr Cloete explained that herd immunity, or population immunity, would only be achieved if more than 70%-80% of the population were immunised.

Details on the various types of vaccines with their efficacy results were provided to Members. Dr Cloete said that Johnson & Johnson was the only vaccine that had a local manufacturer - Aspen in Gqeberha. Information on the development of the vaccine was provided to the Committee and it was believed that the vaccine would work against the new variant 501.V2. The goal was to vaccinate 40 million South Africans.

Vaccines distribution as at 1 Feb - 98 million doses given with the following breakdown:

- Pfizer/BioNTech vaccine - 117,000 doses with delivery beginning as of mid-February with total doses that were for the Q1 supply- based on conditions: indemnity, regulatory; and
- AstraZeneca / SKBio (2,976,000 - 5,028,000) doses. Delivery as of mid/late February, subject to WHO EUL Indicated H1 supply, with 25-35% available in Q1 and 65-75% available in Q2 - based on conditions: indemnity, regulatory

The Department developed an Implementation Framework for the roll-out programme – which was going be posted on the WCG: Health website. The plan was to officially start on 15 February 2021.

Phase I would include Health Care Workers (Public and Private Health Sectors; Care Workers; CHWs; Health Science students; Traditional Healers), estimated target was 133 000.

Phase II would include Essential Workers (Clients in congregate settings; Older than 60 Years; Older than 18 years with Co-morbidities, estimated target 2 million.

Phase III would include Older than 18 years and the estimated target is 2, 9 million.

4.4 04 March 2021: Briefing by the Western Cape Department of Health on its preparations for the third wave; and on the vaccine planning and rollout

Dr Nomafrench Mbombo, the Western Cape Minister of Health, indicated that predictions pertaining to the commencement of the third wave would be unrealistic as no one knew when the third wave would commence. However, data showed, while some countries experienced a long second wave, others like South Africa had a different experience because there was a plateau that was experienced between the waves. The number of infections decreased only to eventually dramatically increase.

The Minister reported that the virus contagion reflects differently in various countries, regions, provinces and sub-districts. This meant a large amount of people could be infected in one area whereas in a different area the infection rate would not be as great. She mentioned that the Eastern Cape was the epicentre of the virus during the second wave of the pandemic.

Statistics showed a marked increase of 5% in the COVID-19 related infections. This was attributed to tests conducted by the private sector on persons who were scheduled to travel or were being scheduled for an operation. Admissions to hospitals and death rates showed a marked decrease by a 22% and 62% respectively. This indicated that the virus had reached a plateau.
Water samples collected from Waste Water Treatment Plants were tested for possible new strains of the SARS-CoV-2. Water samples collected from the Theewaterskloof and four other treatment plants showed no indication of the SARS-CoV-2 in the wastewater system. Tests conducted at the Caledon Waste Water Treatment Plant indicated no trace of the SARS-CoV-2 since 1 March 2021.
The National Ministerial Advisory Committee released a Ministerial Advisory Model (the Model), which portrayed key factors that may influence the commencement of the third wave and the extent of the resurgence infection rate. The Model depicted the mitigating factors that may affect the scale and the cause of the acceleration of the contagion and/or transmission of the infection through the change in seasons, behavioural patterns and movement between provinces.
A sero-prevalence study was conducted of patients that attend health care facilities for non-Covid related incidents. This was to ascertain the sentinel sero-prevalence results, which tested residual ("leftover") convenience samples from patient groups attending health services for the following:

- Public sector diabetic HbA1c specimens (Metro 1661; Rural 1000);
- Private sector diabetic HbA1c specimens (Metro 1000);
- Public sector HIV VL specimens (Metro 1529); and
- Public sector children (ages 15 years) attending RXH & TBH (53% outpatients).

High sero-prevalence may provide a measure of protection against a significant impact in the third wave, but the Department was still planning for appropriate mitigation. Low sero-prevalence indicates a risk of potentially a more severe impact in the third wave, and this should be taken into consideration in planning mitigation strategies for specified areas.

Statistics on COVID-19 cases

The Department indicated that there were 794 COVID-19 patients in acute condition in hospitals of which 471 were located in public hospitals and 323 in private hospitals. COVID-19 hospitalisations continued to decline but there had been an increase in trauma cases.
The metro hospitals had an average occupancy rate of 86% and the George drainage area hospitals at 64%. The Paarl area hospitals were at a 71% occupancy rate and the Worcester area hospitals were at 76% occupancy rate.
Metro hospitals had an 11% COVID-19 occupancy rate. The George area hospitals had a 16% occupancy rate, the Paarl area hospitals a 21% occupancy rate and the Worcester area hospitals were at a 21% occupancy rate.

Oxygen utilisation

In preparation for the third wave, healthcare facilities had to ensure that there was enough oxygen to meet the demand requirements. The public sector total bulk oxygen consumption had reduced to 15.45 tons/day, or 21.44% of the Afrox Western Cape plant for the seven day period ending 19 March 2021. This is compared to 51 tons per day in the first week of January 2021. The Western Cape still had four bulk oxygen tankers allocated for the daily delivery of oxygen supplies.

Vaccine approvals

The Sisonke Programme was implementing the fourth tranche of the Johnson and Johnson vaccine. The Pfizer and Johnson and Johnson vaccine approvals had since been granted by SAHPRA. The Covishield vaccine approval was granted, but the roll-out of the vaccine had been postponed. No submissions were made to SAHPRA on the Moderna and the Novavax & Bharat

Biotech vaccines. Sputnik, Sinovac, and Sinopharm vaccines submitted applications to SAHPRA for approval but at the time no approvals have been granted.

Vaccine acquisition

Dr Cloete informed the Committee that the Sisonke was a research project. He indicated that the Department had not made use of any procured vaccines in South Africa as yet. The Johnson and Johnson vaccines were leftover research vaccine stock from across the world that was returned in batches to South Africa. A total of 80 000 batches of the vaccine were dispatched to South Africa, with another 200 000 batches that must still be returned. Once the additional 200 000 batches are received, it would be allocated to the Sisonke program. This would then conclude the rollout of the Sisonke vaccine role out.
The Department indicated that both the private and public sector hospitals opted to receive vaccines from the national programme. The process to acquire vaccines to supplement the national programme could commence from August 2021 to September 2021. A total of 2000 batches of the vaccine would be rolled out to hospitals and clinics. Melomed applied to be the vaccine centre for the whole of the metro. Special concession would be given to old age homes, people over the age of 60 and frail care facilities.

Vaccine rollout

Phase one of the vaccine would be rolled out in the Central Karoo, Caledon and Overberg regions. The Johnson and Johnson vaccine would be the preferred vaccine mainly due to a single dose administration being cheaper and easier to administer. The Pfizer vaccine would be utilised to supplement the shortfall of the Johnson and Johnson vaccine.
In South Africa, only 50 percent of the health care workers had been vaccinated. Despite socio-economic circumstances, vaccinations were going to be distributed and made available equitably to everyone. A Steering Committee would be considering specific areas to deal with the vulnerable groups. The vaccinations would be administered free of charge at the designated vaccination centres for persons who cannot afford the vaccine.
Participants would be required to have a valid South African identity document to be registered on the database that would be established for persons who had received the vaccine. A challenge would be to register vagrants without an identity document into the system. Registered refugees would also be assisted. Persons with a valid medical aid would be charged for the vaccine. The public and private sector would collaborate in administering the vaccine to everyone. Three sites had been earmarked for the administration of the vaccine in rural areas and Caledon was earmarked for the administration of the vaccine to healthcare workers. The George Hospital had completed 3 618 vaccinations, and was due to complete another 9 760.
No separation between private and public institutions were being made for the roll out of the vaccine in rural areas due to the lack of sufficient capacity. Once, the Pfizer vaccine arrived, additional sites would be allocated to deal with the vaccine rollout programme. The red dot transport system was identified as a possible solution to help transport people to vaccination sites.

501Y.V2 variant and the United Kingdom variant

The Department reported that the 501Y.V2 variant was detected globally. There was no evidence that the 501Y.V2 variant, which originated in South Africa, caused more severe illnesses.
The United Kingdom strand of the virus had been detected at Tygerberg Hospital in South Africa. At the time the variant had not spread and samples of the variant were not found amongst other test subjects. Statistics shown that the United Kingdom variant was more transmissible and severe.

Job appointments

A total of 1 132 contract appointments had been made for the year. Due to budgetary constraints the contracts would have to be reviewed. Critical posts across all categories were mostly looked at when making the appointments. The Department indicated that the budget was already under pressure and that the pandemic only added to the pressure.

Preparedness for the third wave

To ensure preparedness for the third wave, containment measures were put in place in the West Coast, Overberg, and the private sector respectively, with adequate beds and oxygen supply particularly in rural districts.

4.5. 25 May 2021: Briefing by the Western Cape Department of Health on an update on COVID-19 indicators and situational analysis. The Department was also requested to provide an update on the progress of the vaccine roll-out which was due to start on 17 May 2021. The Department was further requested to brief the Committee on whether the B.1.617 COVID-19 variant, first detected in India (Delta Variant), has been detected in the Western Cape and the measures/ preparations that were in place to prevent its spread.

The Minister of Health, Dr. N Mbombo, informed the Committee that the Province was in resurgence according to epidemiologists. It could result in a third wave around the first week or the fourth week of June 2021 depending on the behaviour or any other changes with regards to the vaccination.
The Department had to finalise Phase 1B of the healthcare workers which was 90% of the vaccines. They envisaged about 70 vaccination sites in the metropolitan area and about 200 plus in the rural areas whilst it was mandatory for the people to register before they got vaccinated.
The City of Cape Town assisted the department with access to the Wi-Fi centres in their libraries within the local government space and the Thusong Centres so that it could be able to help people to register for vaccination.

Surveillance & Response Update

Dr. K Cloete, the Head of the Department of Health, reported that the number of daily new COVID-19 cases had increased on an average of 200 new diagnoses each day with a 25% week on week increase (slightly slower than last week). Admissions and deaths continued to increase but the absolute numbers were still very small. On average there were 30-35 admissions and four deaths each day.
The Resurgence Monitor showed a sustained increase for 12 days in the number of new cases in the current week vs the previous week, so the province remained in a resurgence state, although the week-on-week percentage increases had declined.
The Department indicated that it had not yet met the criteria for being in a third wave, but could enter the third wave in 2-3 weeks if the current trajectory continues.

Preparation for the third wave

SA COVID-19 Modelling Consortium predicted a third wave that would be smaller than the second wave in the Western Cape but there was a lot of uncertainty e.g. if different variants emerge. The Department of Health indicated that if they respond strongly and quickly to an increase in cases they can dramatically reduce the number of admissions and deaths. The Department did not want the preparation for the third wave to interrupt the vaccine programme.

Variant first detected in India and UK and checked with the virology labs:

- No identification of B.1.617 (Delta) in the Western Cape.
- No further identification of B.1.1.7 (Alpha) beyond the eight that were reported in early May.
- They experienced some challenges with sequencing machines – so some specimens were still waiting to be sequenced.
- Given the spread of B.1.617 to more than a dozen countries, a travel ban had not been considered to be feasible (informal communication with MAC).
- Vigilance at airports should be maintained.
  The Department of Health reported that it was noticing a very concerning increase in the number of cases and remained in resurgence. Behaviour change was key to mitigate the third wave. In order to delay the onset and/or reduce the size of the third wave (flatten the curve) more people needed to be vaccinated.
  At the time there were 763 COVID patients in acute hospitals (416 in public hospitals and 347 in private hospitals). This excluded PUIs and cases in specialised hospital settings.

Vaccine Implementation update

An estimated 70% target of health care workers were vaccinated via the Sisonke Programme. The balance of health care workers - Phase 1b - commenced on 17 May 2021. 33 900 doses of the Pfizer vaccine to complete Phase 1 and commence with Phase 2, were received in the province on 13 May 2021.
The Western Cape received a total 95 880 doses of the J&J vaccine to vaccinate healthcare workers as part of the Sisonke Programme. The Sisonke Programme started on 17 February 2021 and concluded on 15 May 2021. Phase 2A which was age 60 years and older, the number of vaccines to be administered were 719 668, Phase 2B ages 40 -49 years of 1 631 040, Phase 3A ages 30-39 years of 1 314059 and Phase 3B 18 -29 years of 1 378 556.
A total of 10 289 vaccines were administered during Week 1 of implementation (896 in private sector and 9 393 in public sector). This included healthcare workers, persons over 60 years presenting at vaccination sites and outreaches to Residential Care Facilities (Old-Aged Homes).

The vaccine registration dashboard aimed to address the following:
- How many elderly (60yrs+) were there across the Western Cape and where were the clusters of elderly in communities?
- What was the distribution of the elderly population across the communities which had high levels of socio-economic vulnerability?
- What the estimated elderly population within a 1 to 5km radius of a vaccination site?
- Where additional support should be provided to improve registration numbers across communities?
- What were the surrounding footprints of social facilities (like Wi-Fi sites) which may support vaccination efforts?

4.6. 19 July 2021: Briefing by the Western Cape Department of Health on the progression of the COVID-19 pandemic with specific reference to indicators, modelling and situational analysis on the third wave; and to receive an update on the progress of the vaccine roll-out

Dr Cloete, the Head of the Department of Health submitted projections for the third wave, which were done by a modelling consortium, indicated a peak between mid-July and early August 2021. The most likely scenario, as per the projections, was a third wave with higher numbers than the first wave but lower numbers than the second wave.

Surveillance and response update

Dr K Cloete briefed the Committee on the markers used for tracking the waves of the pandemic included the number of cases/infections, proportion-positive laboratory tests, reported deaths, hospital admissions and oxygen use. The indicators in the third wave were showing signs of flattening in some of the markers. The reproduction number was an important factor. A reproduction number of below one, indicated a decrease in the number of infections and a decline of the wave.
The Department used the national trends to benchmark the level of expectations. On a provincial level, a three-percent increase in the week-on-week number of cases had been reported, which was significantly lower than the percentage of the previous week. The portion of cases that was sent to the laboratory and returned positive was 40%. For the past two weeks, 2 300 cases per week had been reported. Over the same period, 330 admissions per day and 80 deaths per day had been reported. Hospitalisation increased in both the private and public sector with more than 3 000 admissions. The number of reported deaths was in line with the number of excess deaths and was currently exceeding the numbers of the first wave.

Expectations for the third wave

Projections for the third wave, which were done by a modelling consortium, indicated a peak between mid-July and early August 2021. The most likely scenario, as per the projections, was a third wave with higher numbers than the first wave but lower numbers than the second wave. Restrictions and behavioural responses seemed to have taken effect, as the numbers could have been worse. All provinces had a 50% probability of having passed the peak of the third wave.

Triggered third wave response

In mitigate the impact of the third wave, the Department engaged in continued public messaging, published potential increase of restrictions to safeguard the health system from being overwhelmed and recommended restrictions on social gatherings and alcohol sales. In addition, the capacity at both private and public hospitals was increased.

Vaccine implementation update

Since 17 May 2021, public sector sites had been introduced in a phased manner. In addition, 118 private sector sites, including at workplaces, had also been added. Weekly updates of active sites per geographic area were being provided. The Acting Minister of the national Department of Health made an announcement on 23 July 2021 about the special group's programme that would be coming to an end. The age stratified system would thereafter come into effect.

Communication

The message of keeping safe was reiterated. The Department embarked on outreach programmes through door-to-door visits and pop-up sites at SASSA queues and Boxer Stores to counter misinformation and address vaccine hesitancy. Great success had been achieved in reaching people closer to where they lived. More than eight public sector weekend vaccination sites would be opening from 24 July 2021. The sites would increase as the number of vaccine doses and the qualifying age groups increased.

4.7. 25 August 2021: Briefing by the Western Cape Department of Health on the progression of the COVID-19 pandemic with specific reference to the indicators, modelling and situational analysis of the third wave and an update on the progress of the vaccine roll-out.

The Minister of Health, Prof. N Mbombo, gave a brief overview on the state of the province in relation to the third wave of COVID-19. She informed the Committee that the Department of Health's (the Department) presentation would touch on the number of cases as part of the indicators; the number of deaths and hospitalisation; statistics of oxygen usage; healthcare workers' infection rates, and much more. She indicated that the Department would report on statistics for districts, sub-districts, comparison with townships, as well as lessons learnt by the Department from the data gathered. The Department would report on how it was able to navigate challenges and prepare to mitigate the effect of a possible fourth wave.

The Minister indicated that the Department had to come up with innovative ways of getting vaccines to the people. The Department did not get excited about the increased number of vaccinated people, they did not want to leave ordinary people behind. She informed the Committee that the Department embarked on the 'jabs before 'mjolo' ('no dating before vaccination') Awareness Campaign on social media. It was well-known that young people do not like to be perceived as being sickly. The Department had gone to the Central Karoo to bring as many young people as possible and had other upcoming outreach campaigns and the next one would target night clubs in the first week of September. Other upcoming events included the opening of the drive-through vaccinations, which was another method of getting more people vaccinated.

On the trends of the pandemic, she noted that there was a time the Department was more worried about people aged 60 and above, and therefore prioritised them. Although the Department was still worried about this age group, it was now aware that risk factors increased with age, hospitalisation and deaths. There were potential super-spreaders that do not necessarily get sick often. There were also cases of increased numbers amongst young people, but research had shown that mutations should be prevented, since no one was sure if the fourth wave would bring another variant. The Department was doing all it could to prevent another severe, highly transmissible variant. It was for this reason that young people and men were being targeted to be vaccinated. She further informed the Committee that the Department would be visiting the taxi ranks on 10 September 2021 as part of its campaign to get more people vaccinated.

Dr K Cloete, the Head of Department, took the Committee through a comprehensive COVID-19 and Vaccine Update that touched on:

- Surveillance and response update;
- Expectations for the third wave;
- Triggered third-wave response; and
- Vaccine implementation update.

In summary, the Western Cape province was currently at the peak of the third wave, and early signs of a decline were detected, as there were now 3 000 recorded cases per day. A two-percent week-on-week decrease in cases was noted in the Cape Metropolitan area, while the only rural area experiencing an increase in cases was the West Coast region. Although the number of cases was dropping in the Western Cape, there were still quite a lot of active cases and people were still at risk.

The Department would be opening a drive-through at the Athlone stadium in the first week of September. The national Minister of Health, Minister J Phaahla, already launched the Department's hospitality industry vaccination site at the Grand West Casino in the previous week.

Provincial overview saw case numbers have flattened, there was not yet a clear decrease in case numbers. The proportion positive had decreased slightly to an average of 36.1%. The Department

was seeing an average of 3002 new diagnoses each day. Admissions and deaths had slightly decreased, with an average of 295 new admissions and around 93 deaths each day.
The third wave was much longer than the second wave and the peak had exceeded the second wave in several (sub-) districts: Metro: Klipfontein, Mitchells Plain, Northern, Tygerberg Rural: Central Karoo, Garden Route and the West Coast.
There were 3 701 COVID-19 patients in acute hospitals (2 168 in public hospitals and 1 533 in private hospitals). This excluded PUIs and cases in specialised hospital settings. The Metro mass fatality centre had capacity for 240 bodies; at the time 11 deceased (cumulative total of 1 974 bodies) admitted. The overall capacity had been successfully managed across the province.
As at 24 August 2021, the public sector received 1 859 895 vaccine doses: 1 579 230 Pfizer doses and 280 665 J&J doses. Cumulatively, the vaccines administered in the province till to date were about 1.7 million, with 70% of it for the public sector and 30% for the private sector. The department reported that 750 654 people were fully vaccinated as of 24 August 2021, and 444 478 had received the second dose of the Pfizer vaccine.
Private sector sites (90 Metro and 51 Rural) and workplace sites were added sequentially. There were weekly updates on active sites per geographic area. Roving teams would visit satellite clinics. There were pop-up sites at strategically selected locations.
Registration for the age category 18 years and older opened on 20 August 2021. The age category 18 – 35 years dominated uptake since becoming eligible, resulting in the province recording a record number of 53 290 vaccines administered on 20 August 2021. Between 20 and 24 August 2021, a total of 67 936 individuals between the ages of 18 and 34 years received the COVID-19 vaccine.
The CTICC Vaccination Centre of Hope administered 55 883 COVID-19 vaccination by 23 August 2021. By 23 August 2021, the Athlone Stadium Mass Vaccination Site had recorded a total of 3 794 vaccines administered on EVDS. The EMS Pinelands Mass Site would gear up to assist in getting Matriculants vaccinated ahead of the final examinations.
The Department informed the Committee that the Auditor-General conducted a special Vaccination Programme audit in the Western Cape. During the audit, the team focussed on the following:

- Planning and management of the Covid-19 vaccination roll-out programme;
- Availability of the relevant resources at the vaccination sites;
- Stock management and monitoring systems at the vaccination sites;
- Administration of Covid-19 vaccines at the vaccination sites;
- Disposal of medical waste at the vaccination sites; and
- Communication of Audit Observations.

During the audit, the Auditor-General did not identify any shortcomings/audit findings in the Western Cape Vaccination Programme.
The Department utilised the following means of communication to inform the public about the vaccination sites:

- Keeping Safe Messaging
- Enabling easier access (Athlone Vaccination Centre of Hope)
- Boots on the ground taking vaccination to communities
- Localised messaging
- Voices of HCWs “Vaccinate to prevent a 4th wave”

4.8. 01 December 2021: Briefing by the Western Cape Department of Health, on the progression of the COVID-19 pandemic with specific reference to the indicators, modelling and situational analysis of the fourth wave, an update on the progress of the vaccine roll-out, including vaccinations for 12-17 years old and the possibility of boosters for healthcare workers, teachers and 60+ individuals

The Minister informed the Committee that Pfizer had applied to the South African Health Products Regulatory Authority (SAHPRA) to provide COVID-19 vaccine booster shots. At the time, the only people on boosters were healthcare workers who were part of the Sisonke rollout that started in late February. The older persons would get access to the boosters around January, February or March 2022. The Minister indicated that there was an "Alert" phase, followed by a period known as a "Resurgence" and after that there would be a fourth wave. At the moment, the province was not in a fourth wave, instead, it had entered the "Alert" phase. The Department would have to wait for another three days before it could confirm whether the province was experiencing a resurgence or not. With regards to the new Omicron variant, the Minister reported that the Department was still gathering data and evidence, first from the Gauteng data, and then with a proxy using its own samples. The Department was concerned about those in the age group from 50 years and above, specifically ages 50 to 59 years, where a number of people were still unvaccinated. There were about 1.4 million people aged 50 years and older and only about 60 percent of them had been vaccinated. Ideally, the target was to vaccinate 85 percent of people who were over-50 years old by the end of 2021, while 65 percent of other age groups would be vaccinated. Unfortunately, the Department was unable to meet this target. But it had done its part in exploring different innovative interventions, such as pop-up sites in the malls; pop-up sites at South African Social Security Agency (SASSA) offices; taxi ranks; and Emergency Medical Services vehicles that provided music for minstrels and other people. The Minister reported that mandatory vaccination was discussed during the meeting with the universities on 30 November 2021. She stated that universities had been upfront and open about the vaccine mandate. The Department also met with Higher Education Institutions (HEIs). There were 32 TVET colleges and 22 community education and training centers, which constituted a major concern for the Department

Dr K Cloete, the Head of Department briefed the Committee, he provided a comprehensive COVID-19 and Vaccine Update. His briefing coved the following:

- Surveillance and response update;
- Expectations for the third wave;
- Triggered third-wave response; and
- Vaccine implementation update.

Dr Cloete informed the Committee that with regards to surveillance, the Department was tracking every metric being reported on. So far, the province had experienced three waves, and was beginning to see an increase in cases. With regards to the national trend, he reported that there were steep increases in Gauteng and other provinces except the Free State and the Northern Cape. The Western Cape was recording an average of about 100 new cases per day. He stated that the province was in a "resurgence", as an increase of more than 20 percent sustained for seven consecutive days from the 21 to 28 November 2021 had been recorded.

With regards to the new variant, the rapid emergence of Omicron accounted for 68 percent of specimens in South Africa by 21 November, while more than 60 percent of Western Cape specimens had PCR markers for Omicron. As of 30 November 2021, the province had recorded 15 gene sequence confirmed cases with Omicron.

Regarding what the Department knew about Omicron, he reported that scientists were still tracking it to check whether it was more transmissible than the Delta or Beta variants.

In preparation for the fourth wave, the Department appointed and extended the contracts of an additional 863 COVID-19 staff until the end of March 2022. The Department also had 1 471 healthcare workers and support staff, which included 603 interns for the vaccination drive. There were also 803 additional applicants who could still be appointed if and when the need arised. On the status of vaccinations, Dr Cloete reported that although 2.4 million people received the first dose of vaccinations (which was roughly 50 percent) and 2.1 million people were fully vaccinated (accounting for 43 percent), there were still 2.5 million people aged 18 years and older who were yet to be vaccinated.

Administration of booster doses for the general population over the age of 50 years would start during the first week of January 2022 when people would be six months beyond their second dose of Pfizer.

The Department's fourth wave risk mitigation was targeted at the vulnerable. Grocery vouchers had been extended to those over the age of 50 years. The Department's key message remained that vaccination was important; people should wear masks even if they had been vaccinated; windows should be opened to ensure proper ventilation; and more meetings should be held outdoors.

Dr Cloete noted the President announcement on 28 November 2021 that the National Government would establish a task team to consider the possibility of making vaccines mandatory for specific activities and locations. The Department stated that being an employer of healthcare workers they could only make recommendations and not impose a vaccine mandate, considering that an employer-employee relationship would have to be taken into account. This was because this relationship automatically activated the labour laws. It was for this reason that the Department of Public Service and Administration (DPSA) was responsible for developing a policy framework to guide vaccine mandates. He stated that imposing vaccinations would lead to labour issues and court cases. He further reported that the Department was not in a position to impose vaccinations.

5. Protection of the Vulnerable

5.1. 01 March 2022: Briefings by the Children's Institute, University of Cape Town. The briefing dealt with the impact of the COVID-19 pandemic on children in the province and the emerging impact of the COVID-19 lockdown across seven domains.

Ms Lake provided the Committee with a brief overview on how the COVID-19 lockdown affected women and children across seven domains and made reference to each of the domains as follows:

- Children and COVID-19 advocacy briefs;
- Child-centered COVID-19 care;
- The disruption of routine health services;
- Nutrition and food security;
- Violence and injury;
- Child and adolescent wellbeing the future; and
- Schools as nodes of care and support.

Children and COVID-19 advocacy briefs

The briefs highlighted the effects of COVID-19 on children from lower-income communities. It came to the fore that children's needs in terms of healthcare, social and emotional development, quality of life, and child protection during the pandemic were often placed on hold in order to prioritise other services.

To further support children, partnerships were formed between the Children's Hospital Trust, the Children's Hospital and the Children's Institute to release a series of research briefs detailing the effects of the pandemic on children's healthcare, education, early childhood development, nutrition, mental health, and exposure to violence. The briefs were based on data sampled from the Western Cape as a use case to highlight opportunities to increase systems and support for children during crises periods e.g. COVID-19.

The series of eight briefs range from important topics like managing disruption to routine healthcare, addressing nutrition and food security, and encouraging mental health and well-being.

Briefing on child-centred COVID-19 care

The COVID-19 pandemic had a direct impact on children because the health sector focused mostly on adult preventative and containment measures to stop the spread of the virus and managing those at risk of severe COVID-19 disease. In the Western Cape, approximately 12 300 children were documented to have contracted COVID-19 between March 2020 and March 2021. This amounted to 4% of all laboratory cases confirmed in this province. Approximately 3 924 children were admitted to hospitals and 123 child COVID-19 related deaths were reported in the first year. Most of the deaths occurred in young children and in older adolescents. Older children and adolescents were reported to be far more likely to suffer from comorbidities, with these being present in 55% and 62% of children between the ages of 10-14 and 15-17 respectively, compared to only 12% in the younger children.

Hospital admissions were far higher in younger children, children ranging from the ages of 0-4 years constituted of 50% of all admissions of which 1 in 5 had a comorbidity. Only one maternity hospital reported that COVID-19 tests were conducted on five newborns in the first three months and that no further tests were conducted, due to the minor infection rates and clinical impact on newborns. Thousands of children had been affected by the illness, loss of income and death of family members, with five million children around the world estimated to having lost a primary caregiver from March 2020 to October 2021.

Hospitalisations related to an unusual COVID-19 complication in children, known as Multisystem Inflammatory Syndrome in Children (MIS-C) were reported. This is a childhood rheumatic disease similar to Kawasaki Disease (a condition that causes inflammation in the walls of some blood vessels in the body). MIS-C children are generally more ill as it involves the heart muscles, gastro-intestinal tract, brain and kidneys. Global and national health agencies had launched numerous projects to try to understand this “new” condition and how best to diagnose, treat and manage children. Children who acquire MIS-C frequently require intensive care and expensive tests to confirm the diagnosis. Whilst the diagnosis and clinical features of MIS-C had since become clearer, managing children in low-and-middle income communities was challenging as other infectious diseases may mimic the MIS-C and expensive diagnostic tests and treatments are limited and often unavailable. The Red Cross Children’s Hospital and the Pediatric Department of the Tygerberg Hospital treated approximately 70 children with MIS-C in the first 10 months of the pandemic.

The complex needs of children were not anticipated in initial plans to prevent community and hospital spread of the virus and to care for those exposed or infected with COVID-19. The rapid flow of new information which followed the global effort to understand the pandemic also led to much uncertainty about the best ways to diagnose, treat and contain COVID-19 infections in children, leading to significant delays in the development of paediatric clinical guidelines. The first COVID-19 management guideline developed by the National Institute for Communicable Diseases and the national Department of Health was released in February 2020, with an update in March 2020. Yet neither of these documents contained any reference at all to children.
Emerging data suggest that some children, as with adults with COVID-19, experience lingering symptoms weeks to months after infection, this includes fatigue or insomnia, muscle and joint pain, headache and inability to concentrate, persistent nasal congestion and weight loss. One Italian study reported that more than 40% of children had at least one problem two months after infection.

Quarantine and isolation facilities were set up with adults in mind and children over the age of 12 years were placed into single rooms without family support or supervision. Intermediate care facilities for children were not an option as the risk of super spreading to other vulnerable children

and staff was a probability. Social workers were reluctant to place children without testing therefore primary health care facilities were capacitated to do this.

Briefing on the disruption of routine health services

The COVID-19 pandemic had led to disruption in delivering routine healthcare services. Most medical facilities focused on COVID-19 infected patients and reduced access to standard health care services. In some instances some facilities either reduced or stopped offering some standard medical services or were overwhelmed with treating COVID-19 patients presenting acute symptoms of respiratory infection.
Health services for adult health were directed as follows:

- Reallocation of resources from other non-priority areas;
- De-escalation of some child health services;
- Cancellation of non-urgent Outpatient Department treatment; and
- Cancellation of elective surgery/procedures.

It became prevalent that nurturing care for children should be promoted especially for young mothers. Schools reported an increase in pregnancies during lockdown. Pregnant young girls should be encouraged to stay in school and preventative measures should be put in place to prevent further pregnancies. There have also been reports of increased anxiety and suicidal consideration amongst adolescents. Greater effort should be made to improve access to adolescent-friendly healthcare during pandemics e.g. COVID-19, including access to contraception and mental health services. Leadership and advocacy for child health is needed at every level of the health care system to protect, sustain and rebuild child health services. Surveillance systems should be strengthened in order to identify children at risk and to optimise the use of community health workers in maternal and child health to reach out and bridge the gap between communities and health services.

Briefing on nutrition and food security

Food and nutrition security is when all individuals have reliable access to sufficient quantities of affordable, nutritious food to live a healthy life. Good nutrition (or nutrition security) also requires having enough of the right foods, but in addition, it requires having access to adequate feeding, caregiving and hygiene practices, as well as access to health, water and sanitation services. Nutrition security thus depends on having access to a healthy diet which provides all nutrients required for a healthy life, and being healthy so that the body can make optimal use of these nutrients for its different functions. Food security is necessary, but not sufficient, to ensure nutrition and to prevent childhood malnutrition. Children also need their caregivers to provide them with appropriate feeding, caregiving, hygiene, and health-seeking practices in order to grow, develop and stay healthy. Studies have shown that one in ten children go hungry and that one in three children live below the food poverty line. Approximately 48% of child hospital deaths were associated with moderate or severe acute malnutrition.

Reports show that one in eight young children are overweight or obese. Food insecurity and deficiencies of essential nutrients are widespread among the poorest of the population in many affluent countries. Food insecurity often leads resource-constrained households to feed their families cheap, calorie-dense fast foods instead of fresh fruits and vegetables, meat and dairy, which are typically much more expensive. As a result, food insecure households in poor households often have poor quality diets containing high levels of saturated fat, refined sugar and salt, which leads to severe problems of overweight and obesity not only in adults but also in children. Obesity and overweight lead to stigma and social problems, and more importantly, they are the most significant risk factors for a number of health related problems including

cardiovascular diseases, diabetes and some forms of cancer. Food insecurity and malnutrition are not just problems of poor.

Governments throughout the world need to find appropriate solutions to protect the food security and nutrition. The disruption of routine health services made it harder to identify and support children at risk of acute malnutrition. Child hunger is expected to intensify due to a decrease in Child Support Grant. The Grant allocation is valued at R460 a month or R15 a day. This allocation has failed to keep abreast with escalating food prices and inflation rates.

To improve on food security of children, the following needs to be taken into consideration:

- Increase the Community Service Grant to the food poverty line and address barriers to early uptake through Regulation 11(1) of the Social Assistance Act, 2004 (Act 13 of 2004);
- Use taxes, subsidies and price controls to limit food price inflation;
- Sustain and enhance the quality of early childhood development and school feeding;
- Strengthen surveillance and referral systems to identify and support children at risk of malnutrition;
- Ensure measures introduced to alleviate hunger (such as school meals and food parcels) are nutritionally balanced and do not increase the burden of over nutrition and micronutrient deficiencies; and
- Use licencing and zoning regulations to ensure a more equitable spatial distribution of healthy food retailers and limit the number of unhealthy food outlets.

Briefing on violence and injury

Reports have indicated that one in two women have experienced physical and sexual intimate partner violence in their lifetime. During lock down children's rights activists raised concerns about how rising unemployment, food insecurity and the stresses of lockdown increased the risk of violence and injury in certain households. The disruption of social and child protection services made it harder for women and children to access critical services.

Child protection as an essential service should be established and that local response teams should facilitate access to the support services at community level. There should be collaboration amongst health, education and child protection services, schools, early childhood development programmes, health facilities and contact tracing teams to identify and respond to cases of violence and abuse. Family violence can also lead to adverse health and mental health outcomes, including a higher risk of chronic disease, depression, post-traumatic stress disorder, and risky sexual and substance use behaviours.

During lockdown the Red Cross Children's Hospital (RCH) continued to see similar numbers of child abuse cases during the lockdown compared to before. Although the hospital has seen a decrease in motor-vehicle related accidents, preventable injuries and intentional violence towards children continued. Currently there is no evidence that the banning of alcohol mitigated the risk of abuse in any way. A decrease of 56% in road traffic injuries during the hard lockdown was reported, while injuries in the home such as burns and falls increased over the same period.

Briefing on mental health

At least one in seven children had been affected by the compulsory lockdown instituted due to the COVID-19 pandemic. The disruption to routines, education, recreation, as well as concern for family income and health is leaving many young people feeling afraid, angry, and concerned for their future. Reports have shown that it is important to build capacity for families and frontline workers in schools, early childhood development programmes and health care services to help children to cope.

The mental health of children is further threatened by the environmental factors such as commercial threats through the marketing of harmful substances. Other factors that jeopardise mental health were sleep disruption, loneliness and alcohol abuse. A study conducted in the United Kingdom has shown that 29% of adolescence between the ages of 18 - 29 years have had self-harm or suicidal thoughts. A total of 43% indicated that their lives had taken a bad turn with the commencement of lockdown where 25% indicated that their lives improved.

Specialised child and adolescent mental health services remain extremely limited in South Africa. Women have been particularly hard hit by unemployment, food insecurity, domestic violence and an increased burden of childcare. During the state of emergency, essential services and designated child protection response teams need to be established and accessible to communities at local level.

Briefing on schools as nodes of care and support

The opening and closing of schools during the COVID-19 pandemic has been a highly contested issue. Challenges arose between minimizing the disruption to children's education while also keeping children, educators and the broader school community as safe as possible. While schools have the education of learners as their primary mandate, they also have the potential to play a pivotal role as nodes of care and support during crises such as the COVID-19 pandemic. The school is also required to be the setting through which the necessary preventive and support measures can be provided.

The COVID-19 pandemic has brought into focus the integral relationship between the health and education of children. The health of a child influences the extent to which they can fully attain their education potential, and the level and quality of education impact on their longer-term health. The threats posed by the COVID-19 pandemic to both the health and education of school-going youth are therefore likely to have devastating immediate and long-term impacts on children and the broader society. Schooling during the pandemic posed many challenges.

Learner absenteeism, particularly in the youngest grades, was a key factor driving learning losses. Learners in historically disadvantaged schools recorded learners losing 50% - 75% of contact time. In South Africa, schools closed nationally for the first three months of the lockdown, with a gradual phased return, coupled with online learning. Most children spent considerable amount of time out of school since March 2020 when the COVID-19 pandemic started, with an estimated 750 000 children dropping out of school since the pandemic began. The rotational system disrupted teachers' ability to complete the curriculum, negatively affecting learners' mastery of core skills and content knowledge, particularly in the younger grades where children learnt foundational concepts. Despite matriculants continuing to attend classes, grade 12 learners from low Supplemental Educational Services (SES) schools were estimated to have lost around 35% of contact time. Online learning during the pandemic amplified socio-economic divisions. While 90% of South African households have access to a mobile phone, only 60% could access the internet via their mobile phones. Over 2000 or 0.6% of teachers lost their lives between March 2020 and late May 2021. It was predicted that learners would be an entire year of learning behind their pre-pandemic peers.

Given the absence of psychosocial support for the majority of young South Africans, the school becomes critical in mainstreaming and promoting mental health, particularly during periods of adversity. Teachers need to have a basic understanding of mental illness to grasp how trauma affects self-esteem, behaviour and interpersonal relationships. There is a need to move away from the stigma and ignorance of trauma, towards normalising children's experiences associated

with mental illness. Creating emotionally safe spaces where children can learn to express themselves and be taught the skills of emotional literacy.

Many direct and indirect health effects for school children occurred during the pandemic, some aspects were managed well while others have presented ongoing challenges. Some of the health-specific aspects that required attention include:

- Psycho-social support and teacher wellbeing;
- Build the capacity of teachers to support learners who are struggling with emotional and psychosocial issues;
- Provide psychosocial support for teachers who are experiencing their own emotional distress;
- Strengthen & centralise the role of School-Based Support Teams within these collaborations (referrals); and
- Strengthen partnerships between schools, universities and districts

5.2. **11 June 2021: Briefings by the umbrella bodies responsible for care homes for the aged. The organisations briefed the Committee on the planning and readiness of the vaccine rollout programme at their facilities. The organisations were represented by Ms Christine Quickfall of BADISA, Ms Lucia Smuts of the Afrikaanse Christelike Vroue Vereniging (ACVV) and Ms Kirsten Veenstra of the Cape Peninsula Organisation for the Aged (CPOA).**

Presentation by ACVV

ACVV informed the Committee on the challenges pertaining to the availability of the vaccine at vaccination centers. Staff from the care facility in Bellville indicated that they had to wait in long queues at Karl Bremer Hospital despite making prior appointments. They informed the Committee that on the morning of the vaccination for residents at the Bellville facility, ACVV was informed that the facility was not registered to receive vaccinations. The official on duty enunciated that only a limited amount of vaccines could be administered, as they were still waiting for the National Department to confirm that the vaccinations can be administered at that care facility. After being informed by the representative of the Department who visited ACVV which date the vaccinations would be taking place.

ACVV advised that the elderly at Community-based Care and Support (CBCS) centres, who were registered, were not receiving voucher numbers. They further advised the Committee that some facilities already administered the flu vaccines prior to the announcement of the Covid vaccine programme. A 14-day waiting period must be observed after administering a flu vaccine, which meant that some residents could not be vaccinated. This resulted in a delay during the rollout at these facilities. Management felt that there was a lack of coordination between the various stakeholders.

The Bellville facility was unable to upload the Electronic Vaccination Data System (EVDS) template. Information had to be e-mailed to the Head Office for inclusion into the database.

Concern was raised regarding the delays pertaining to the rollout of vaccination sites for the elderly and people living with disabilities were brought to the attention of the Committee. In addition hereto, the Committee was requested to aide staff at child and youth care centres, classified as essential workers, in order to qualify for a vaccination opportunity during the second vaccination rollout programme.

The ACVV thanked Local Government and communities, especially in the rural areas for their support. They indicated that community members in Swellendam were assisted with the vaccine registration process by staff on the Transnet Phelophepa health train from 13 to 14 April 2021.

Presentation by BADISA

The Committee was informed that approximately 45% of the staff at BADISA opted to not be vaccinated. A concern was raised regarding the inflated figure provided of staff, especially amongst female employees, who opted not be vaccinated. Approximately 73% of residents at BADISA were vaccinated. BADISA advised that through continued awareness programmes and visual proof the remaining 27% of the residence who opted not to be vaccinated would utilise the opportunity to get vaccinated during the rollout of the second phase.
Stigmatisation and fear pertaining to the impact of the vaccine were constantly being addressed through multiple awareness interventions and educational programmes introduced by the organisations. All information pertaining to COVID-19 should be verified by the Western Cape Government and the World Health Organisation (WHO).
Social media platforms were utilised to register members of the public to receive the jab and to raise awareness regarding the vaccine. Regular engagements with staff, support groups and families of residents took place to discuss COVID-19 treatments, and to address persons with conservatorship to decide on whether the vaccine should be administered to a conservatee.
A management information system was implemented to track the reasons for people not interested in getting vaccinated. Caregivers, social workers and nurses at some of the institutions queried the safety of the vaccine on themselves, unborn babies and gestating mothers. Medical professionals have also been requested to assist by advising patients of the benefits of being vaccinated.
The Management of BADISA thanked the professional and compassionate staff of the Department of Health for their level of responsiveness and for including Sister Klopper on the Advisory Committee. Ms Quickfall highlighted that there were still challenges in terms of the vaccination of essential staff and social workers at youth care centres who were not in line for vaccination. The organisation needed the assistance of the Committee to have staff at child and youth care centres classified as essential workers.

Presentation by CPOA

The CPOA registered all its residents, whether in care facilities or independent residents. The organisation has 27 units, of which seven had been successfully vaccinated its residents. Staff at a number of the units were being trained in order for the organisation to conduct its own vaccination rollout when the second round becomes available. Residents were encouraged to get vaccinated but there were individuals who have opted not to be vaccinated. The organisation had its own Covid unit which helped with getting symptomatic people at the villages and care centres into dedicated Covid units. She indicated that both the Department of Health and the Department of Social Development required the same documents to be completed. She recommended that the documents be centralised thereby streamlining the process to eliminate confusion.
The CPOA oversees twelve facilities with 2 364 residents of which 897 had been vaccinated and 129 opted not to receive the vaccination. Not all facilities had received vaccination dates, but residents were being informed about the dates vaccinations will be taking place and at which facilities it will be taking place. Notices from the Department of Health were being displayed on notice boards. Managers reached out to residents by encouraging them to get vaccinated. The CPOA Management thanked everyone for their assistance in getting dates for the majority of the facilities. They indicated that two of the facilities received dates which were cancelled on short notice and that the organisation was still await for the new dates to be submitted.
Indemnity forms and refusal forms were sent to resident family members for completion. The signed forms were being kept on file. There was a positive response to the programme. Approximately 129 of the 2 364 residents opted not to be vaccinated. The number might decrease as more people opt to be vaccinated

5.3. 11 June 2021: Briefing by the Department of Health's Division of Child and Adolescent Psychiatry and the Jelly Beanz NGO on: (i) The effects of the pandemic on the youth and their mental well-being; (ii) The exacerbating factors which influences this; and (iii) Any additional insights for policy makers

Presentation by the Department of Health's Division of Child and Adolescent Psychiatry

Mental health conditions

Dr Keith Cloete, Head of the Department of Health, briefed the Committee on the impact of COVID-19 on the mental health of the youth and population. He indicated that mental health is generally equated with a severe psychiatric condition that had to be dealt with constructively. Mental health conditions can be viewed as a continuum from none-severe to very serious. A continuum with five indicators lists the conditions as follows:

- Psychologically healthy and mostly unaffected;
  This from a psychosocial aspect indicates that the affected person is generally healthy and mostly unaffected.
- Psychologically healthy but experiencing stress;
  This indicates that the affected person have experienced episodes of anxiety and can deal with the stress, but might not be able to cope with the stress.
- New cases of sub-clinical mental distress;
  This indicates that the affected person is suffering from mental distress but at this juncture it has not manifested as a mental condition.
- Existing and/or new common mental health conditions;
  This indicates that the affected person is in actual fact suffering from a mental health condition. The affected person might even be suffering from an anxiety disorder or might be suffering from depression.
- Severe psychosocial disability
  This indicates that the affected person is already suffering from a mental health disorder that is causing this disability.

The COVID-19 pandemic has instilled feelings like fear and anxiety in the majority of the population. At some point most people have been suffering from the fear of contracting COVID-19. These feelings have been exacerbated in those with comorbidities and heightened as family members are infected or dying from the virus. Uncertainty about the future has created further stress and anxiety. Secondary effects from a psychological perspective can veer into suicide, self-harm and substance abuse. This can also lead to violence and abuse. These are all the social aspects stemming from the primary effects of the lockdown restrictions.

Proximal and distal drivers of poor mental health

Proximal drivers are issues that pertains to an individual's basic needs eg. Stable housing and enough food amongst others. Distal drivers refer to crises like economic downturns. Hunger is a proximal environmental driver that impacts on an individual's mental well-being. COVID-19 has impacted households negatively in that many have lost their jobs and income. This reportedly led to 35% of households running out of money for food, 17% reported household hunger and 14% reported child hunger.

Child and adolescent mental health

Dr Rene Nassen, Child and Adolescent Psychiatrist at Lentegeur Hospital, informed Members that prior to COVID-19, there had already been challenges pertaining to children's mental health. Social and economic challenges experienced in South Africa led to high rates of adverse childhood experiences. There was a high rate of trauma and other related conditions particularly in adolescence. When the child is exposed to this environment while still under the caregiver's supervision, a lifelong impact on the child's mental health can be expected. These traumatic experiences were exacerbated by the COVID-19 pandemic.

The Childhood, adolescent mental health services was an under resourced discipline worldwide. The lack of professional intervention from a mental health standpoint showed a significant increase in adolescent's levels of depression, anxiety and ultimately suicide. Policies were recommended for an urgent response plan in terms of childhood and adolescent's mental health intervention during the period of the pandemic. Further hereto, recommendations were made for direct and collaborative networks between clinicians and other sectors in order to help children and adolescents who were struggling to cope under the pandemic

Concern was raised regarding the huge impact of hunger on the individual's mental wellbeing. All heads of departments were requested to work collectively to respond to the issue of hunger and its effect on mental wellness. The Department was working closely with other departments such as the Department of Cultural Affairs and Sports, the Department of Education, the Department of Economic Development and Tourism, and the Department of Agriculture to provide sustenance to children in poor communities.

The COVID-19 mental health impact and response provide clear and correct information, parental guidance, and continuity of care via tele-psychiatry, access to obtaining medication, crisis intervention and availability of emergency care. Caregivers were not always have the means to afford the astronomical fees associated with specialist rates. Dr Nassen advised that it was challenging to implement telepsychiatry programmes. The internet is crucial to gain access to information provided on mental health related matters as the information is only accessible to individuals who have the necessary resources and data/Wi-Fi connections.

Insights from the National Income Dynamic Study (NIDS) and the COVID Rapid Mobile Survey (CRAM) conducted on adults indicated a consistently higher rate of depressive symptoms during the pandemic. Approximately 24-29% positive screenings were made compared to 21% pre-COVID. Others experienced 52% depressive symptoms since the start of the pandemic. The study showed that fewer depressive symptoms in terms of child hunger/food insecurity were reported. Self-assessed health indicators showed that a larger number of the poor reported ill health and others reported an increased number of depressive symptoms. Funding was required to drive the NIDS and the CRAM as a recovery plan. Pre-existing challenges recorded lists poor ambulance services in the regions where the children suffering from mental health reside. There was a shortage of resources to provide adolescent with mental disorders with the acute therapeutic aide they require. Existing services had decreased and partnerships with other sectors had deteriorated.

An emerging framework action plan indicated strategies should be implemented to strengthen sustainable access and production of affordable food. That there should be social cohesion through cultural and sport initiatives. Nurturing relationships should be fostered and strategies should be implemented to provide learning and economic opportunities for the youth. Strategies to meet the basic health needs of the youth is crucial as early interventions would minimise high risks like adolescent suicide amongst others. Interpectoral collaboration across all programmes will provide better models of care which will focus on early intervention initiatives.

Presentation by the Jelly Beanz

Ms Edith Kriel, Executive Director, Jelly Beanz, briefed the Committee on the impact COVID-19 on the mental health of youth. Jelly Beanz is a non-profit organisation (NPO) that provides response and preventive child protection services to children and their families in the Western Cape.

She informed the Committee that the mental health of children is a long term concern predating the advent of COVID-19 pandemic. The vulnerable position that children are in, was highlighted as problematic even before the COVID-19 pandemic as nearly one in every three children was sexually abused in South Africa. There had been a significant increase in violence during the lockdown, and this had taken a toll on children's mental development. A case study conducted on children residing in the Western Cape reported that 21.7% of the children sampled met the criteria for post-traumatic stress disorder. Individuals had a unique response to adverse experiences and how they cope with and manage their experience.

The increased consumption of alcohol promoted social ills like gender-based violence. Child-on-child sexual abuse also increased significantly. Pornography was listed as one of the contributing factors, though it was not construed to be the only contributing factor promoting sexual abuse. Some were caused by children's bonding problem with their caregivers. The problem was exacerbated by children who yearn for human contact. They reached out to other children for affection, which in turn was misconstrued as sexual advances. The death of a caregiver or both parents resulted in children being removed from their homes which can also have a debilitating effect on the children's mental health.

Sex education is vital for children to understand their own sexuality and the do's and don'ts about sexuality. Ms Kriel advised that children needed to be taught about sexuality, instead of being told to look away when sexual content was being displayed. Caregivers needed to explain and provide guidance in a mature manner.

A major concern was raised regarding the education of children especially those who do not have access to online study material. Grade 10-12 learners expressed their concern regarding the loss of schoolwork during the lockdown. They reported that there was no adult support, and were subjected to looking after siblings and doing chores. High levels of stress and isolation can affect the brain development of young children negatively.

Concern was raised that most child protection services, an essential service that should remain operating during the lockdown period, had been closed. Emergency protection was not available due to crucial staff working from their place of residence. No forwarding contact details were made available for caregivers to access the care required. Child line reported that a case study conducted indicated that 33% of the children sampled requested that more support in the form of home visits be provided, some requested counselling for emotional support and others wanted to report emotional abuse.

Ms Kriel advised that many non-profit organisations were overwhelmed trying to provide services to children and families. However, statutory functions can only be provided by statutory designated child protection organisations. Organisations like Jelly Beanz required the support of the relevant organisations in order to protect children who needed their support. She indicated that it should also be noted that an emergency or disaster management plans needed to be developed to combat the challenges of the previous year, thereby ensuring that children and families are provided with better services should a disaster happen again. She listed the following 11 key issues that should be addressed:

- Document the Covid-19 child projection history;
- Ensure that there is a clear leadership in the emergency plan;
- Ensure that emergency planning is conducted at every level;
- Ensure functional toll-free helplines;
- Map resources that may be called upon during emergencies;
- Ensure a functional communication and coordination process;
- Ensure basic needs are met in emergencies;
- Ensure that front line responders are trained in psychological first aide;
- Involve children at every level of the emergency planning process;
- Provide support for the workforce, whist supporting children; and
- Plan for regular monitoring evaluation.

In conclusion Ms Kriel acknowledged the importance of engaging with the Commissioner for Children, Early Children Development (ECD) practitioners and other experts that worked on children's' issues. She said that the presence of organisations such as Jelly Beanz in poorer areas was very scarce. To her knowledge, Jelly Beanz was the only children's mental health organisation from the Red Cross Children's hospital in the West Coast. She stated that the government and society were failing the children in terms of looking after their mental health. Most of the referrals to Jelly Beanz were children who were sexually abused. She further indicated that sexual abuse was merely a small portion of the problem and that there was a larger scale of mental illnesses among children that still needs to be explored.

6. Economic Recovery, Support and Livelihoods

6.1. 11 June 2021: Briefing by the Department of Economic Development and Tourism on: (i) Youth employment, support provided to young people to help pursue jobs and keeping young people connected to job opportunities; and (ii) Measures to reduce social exclusion, job search resilience and reducing discouragement of young people.

Presentation by the Department of Economic Development and Tourism

Minister Maynier in his opening remarks informed the Committee that the amount of young people without jobs in the country was staggering. He indicated that the top priority of the Department of Economic Development and Tourism (the Department) was to create opportunities for growth and jobs in the Western Cape. He elaborated on the Department's interventions, which pertains to supporting the youth through skills development programmes, social inclusion and job creation that would be derived from partnerships. The partnerships would be established to develop experiential learning workplace opportunities for youth and vulnerable unemployed groups.

The Western Cape labour force consists of 3, 018, 00 individuals of which 680,000 were unemployed but NEETS were 1, 748, 000. Approximately 58% of the provincial workforce were not economically active. Youth up to the age of 24 made up 43% of the unemployment rate and 53% of the provincial population over the age of 20 did not have a matric qualification. This was construed to contribute to social ills such as substance abuse, crime, poor health amongst others. Government took cognisance of these challenges and developed a plan to aid the youth through skills development programmes that could lead to employment. The Work Place Skills Development Programme was conducted in collaboration with other government departments, training institutions, civil society and business. The aim of the programme was to create experiential learning and work placement opportunities for young people who were unemployed. They indicated that the experiential learning and work placement opportunities was implemented through the following three sub-programmes:

- The Work and Skills Programme;
- The Artisan Development Programme; and
- The ICT Technical Skills Programme.

Work and Skills Programme

Approximately 4000 beneficiaries were assisted through the Work and Skills Programme in the 2020/21 financial year. Approximately 60% of the beneficiaries who completed their workplace training were absorbed into the respective organisations where they conducted their training.

The Artisan Development Programme

Approximately 423 beneficiaries were provided with experiential work opportunities through host companies. They were afforded an opportunity to work in jobs that require artisanal and technical skills.

The ICT Technical Skills Programme

Through the ICT Technical Skills Programme, 80 of the graduates were provided with entry level opportunities. Specialised ICT courses were provided to gain demand led skills including micro software development and Java to increase the employability of the youth in the sector.

Upscaling skills and workplace opportunities

The Department also partnered with the College of Cape Town, the National Skills Fund, the City of Cape Town and the Business Process Outsource (BPO) industry to launch the BPO academy. The Academy would develop the bespoke industry certification in response to the changing industry needs. Further partnerships were formulated with the Western Cape SETA Cluster, Western College SETA Forum, Western Cape Government Inter-Departmental and Municipality collaborations, SMME Booster Fund to upscale skills and work placement opportunities. The public and private partnerships provides a gateway for skills training work placements with financial support.

Sourcing companies via selection criteria

Participating companies were evaluated in accordance with the following criteria:

- The value of the company contribution to the beneficiary. Some companies provide up to 200% more financial support than what was provided by the Department of Economic Development and Tourism;
- The nature of the training was taken into consideration and whether an NQF level of the accreditation and vendors training is provided e.g. Microsoft and vendor specific training;
- The cost to create a job was evaluated at R10 000; and
- The commitment of the company to employ the individuals who have received training;
- The company must commit to further employment.

Once the criteria was established a threshold was set in terms of eligibility for the company. The employment of a beneficiary amounted to R25 800 and only companies that provided the training were allocated with the required revenue. In some instances, the beneficiaries once qualified seek employment at other companies and do not remain in the company which provided the training.

Beneficiary considerations via selection criteria

- Beneficiaries must reside in the Western Cape;
- The individual must be younger than 35 years. There were however specific instances where exceptions were made;
- The beneficiary must be unemployed and not have worked for the host company before; and
- The beneficiary must not be a family member of any of the directors of the host company.

Business Process Outsourcing

The main objective of the Business Process Outsourcing (BPO) was to develop unemployed youth as call centre agents. Once the youth had been developed, they were provided with employment opportunities in the Business Process Services (BPS) or the Business Process Outsource (BPO) industry. Experienced learners were provided with a stipend for a period up to 12 months which amounts to R2 500 a month for experiential learning opportunities, R3 000 for the working skills programme and R7 000 for the artisanal training programme. All revenue streams subject to the existing agreements of bargaining councils. The R7 000 for the artisanal training programme was not entirely covered by the Department, contributions were made by the relevant host companies to consolidate the final amount.
The initiative had contributed to job opportunities realised in the sector. The industry employed approximately 60 000 people a year. A total of 1 166 jobs were realised in the 2020/21 financial year. The industry was highly competitive and this had resulted in an increased growth of the sector.

Work and skills

The Work and skills programme focused on the BPO and Technology sector. Unemployed youth were placed in companies to gain workplace experience. Approximately 200 unemployed youth were projected to benefit from the Experiential Training Programme over the financial year. The Department of Education which was also one of the partners in the programme, indicated that there was a very high dropout rate particularly in the formative basic education years. The Department therefore provided a stipend for Early Childhood Development (ECD) individuals. Partnerships were formed with companies that provided the hard skills for ECD learners. These programmes provided soft skills and shape behavioural characteristics that were suitable for employment. Further partnerships were formulated with local government which was able to provide work opportunities across the province. The Department facilitated some of the work opportunities at local government level.

Artisan development programme

Approximately 269 artisanal candidates were placed in the programme for the 2020/21 financial year. The programme would provide workplace training for 200 unemployed youth beneficiaries. The programme was costly, therefore the bulk of the finance would be derived from external funders. The partnerships had provided the Department with more than R100 million in support of skills development initiatives. The SETA's were the largest funders for the artisanal development priorities. MerSETA provided R40 million for experiential development candidates.
Youth supported from April – June 2021
The Department's target for the first quarter for the total youth placed was listed as 300. The target was exceed by 151 as they had placed 451 for the quarter. A total of 318 females and 133 males were placed. The youth supported who were younger than 20 years old amounted to 148 and the ones aged from 21-25 amounted to 187.

Small Medium and Micro Enterprise (SMME) Booster Projects

The key purpose of the Booster Fund was to support businesses to deliver on their outcomes in terms of job creation and sustaining jobs within companies. The SMME Booster fund supported 16 businesses during the 2019/20 and the 2020/21 financial years. One of the projects supported by the Department is the False Bay TVET College-Centre for Entrepreneurship and Rapid Incubation. Through the programme, the Department was able to support 20 youth owned business that were located in areas such as Mitchells Plain, Khayelitsha, Gugulethu and surrounding areas. Approximately 50% of the businesses that were supported were women

owned. The support was in the form of a pre-incubation process. The process dealt with reviewing business plans that could be transformed into a start-up business. The programme was further expanded from structured incubation support for start-ups to establishment. Business with manufacturing capabilities were provided with access to engineering and woodwork factories equipped with machinery, tools and production support for the development and manufacturing of new products.
Minister Maynier concluded the department's inputs and in his closing remarks assured the Committee that the Department would continue to work hard to create more opportunities for young people, as well as attract more investment so that more people could be absorbed into the workforce.

7. Schooling and Education

7.1. 11 June 2021: Briefing by the Cape Higher Education, CPUT on: (i) The effects of the pandemic on learning at Higher Education Institutions; (ii) Adapting learning to COVID-19 restrictions; and (iii) Insights for policy makers.

Presentation by the Cape Higher Education, Cape Peninsula University of Technology

The Higher Education sector's response to COVID-19

Prof Mellet Moll, Compliance and Risk Officer: Cape Peninsula University of Technology (CPUT), briefed the Committee on the COVID-19 response in the higher education sector. He indicated that CPUT's vaccination programme initiative was derived from the Minister of Higher Education, Science and Innovation. The CPUT focused on five priority areas as follows:

- National COVID-19 trends;
- Presidential family meeting;
- Ministerial guidelines;
- Higher Health directives and protocols; and
- Institutional response.

CPUT monitors COVID-19 trends and have developed their own models to predict COVID-19 trends. A Presidential family meeting was held to discuss the models, which were instrumental in the formulation of the Gazetted guidelines for education and training.

CPUT's COVID-19 statistics

CPUT recorded the lowest COVID-19 figures in the sector, with 354 positive cases and 336 recoveries recorded on 16 July 2021. Approximately 175 personnel and 179 students tested positive between 9 and 16 July 2021. None of the CPUT staff and students were admitted to high care or intensive care. No on-campus transmissions were recorded throughout the course of the pandemic.

COVID-19 Health Cluster

The institutions response to the pandemic provided them with the accolade as being the leading sector in their response to COVID-19. A Business Continuity Planning meeting was held with CPUT's executive Management, where all the health related skills and support services were represented to devise a plan on how to deal with the ramifications of the pandemic. Stemming from this meeting, a Health Cluster was established. The Health Cluster had become the cornerstone of the institutions COVID response. It tracked and oversaw all operations and campus activities. The Health Cluster met every second day.

Two additional committees were established namely the COVID-19 Command Centre (the Command Centre) and the COVID-19 Strategic Think Tank (the Think Tank). The Command Centre met every Friday afternoon to review the COVID-19 activities and to plan ahead for the coming week. The Think Tank planned ahead for the next phases of the pandemic and ensured that the intuition remained prepared for any future eventualities.
This structure had become the cornerstone of CPUT's success in combatting the virus. The academic project was directed by CPUT's Deputy Vice Chancellor for Teaching and Learning and six Deans of faculties. The Carousel Model had four modalities of multi module teaching and learning. This included online learning through data provision and device provision. This COVID-19 Strategy was developed and presented to the Council and ManCom. When fluctuations in the lockdown levels occurred or when the semester changed, a contingency plan was released and distributed to the CPUT community.

Vaccination of CPUT Community

The Health Cluster identified the CPUT community vaccination as its next milestone in its COVID-19 response. A former cafeteria facility was converted into a vaccination station at almost no cost to the institution. Through collaborations with the Health Cluster and the Faculty of Health and Wellness Science, a CPUT Vaccination Strategy was developed and submitted to the executive management. The strategy was approved by the Executive Management and Higher Health. The strategy entailed providing 90 000 vaccines for a period of 500 days and a period of 2 500 weeks. This ensured that up to 40 000 CPUT staff and students could be vaccinated. The remaining vaccinations could then be utilised to vaccinate the CPUT community members to ensure a herd immunity of 23 000.

SACCO Hall (CPUT vaccination centre)

SACCO Hall received accreditation and was visited by the Department of Health. It was alluded to be one of the best vaccination sites in the region outside of Groote Schuur and Tygerberg Hospitals. The institution recognised the lack of capacity to administer the strategy among the many other higher learning institutions, such as technical and vocational education and training (TVET) colleges. The institution therefore opted to manage the vaccination programmes in many TVET colleges. CPUT and many other leading universities had developed a Higher National Vaccination Strategy which was being circulated, and had reached the inter-ministerial vaccination committee. Higher learning institutions played a vital role in the vaccination process. All members of the community were utilised as agents of communication campaigns. All COVID-19 responses were quick, well executed and managed in minute detail and with minimum disruptions. The lifestyle of the COVID-19 response team members were in line with institutional practices. The Gazetted directives from the last Presidential announcements were still in place until 26 July 2021 after which the latest Level 4 Contingency plans would be released.

Budget

The CPUT has included a budget for COVID-19 for the 2021/22 financial year. This is to ensure that the institution had enough revenue to be compliant with its COVID-19 guidelines and protocols. The institution received budget approvals after it had been scrutinised by the Department of Education.

8. Intergovernmental Relations and Community Cooperation

8.1. 13 January 2021, Briefing by the Western Cape Premier and the Director-General of the Department of the Premier on the Adjusted Alert Level 3 Lockdown

The Premier of the Western Cape, Mr A Winde, informed the Committee that South Africa was on the verge of hitting the peak during the second wave of the pandemic and that people could not relax their COVID-19 precautions, as hospitals were full and there was immense pressure on the health system overall. As at 13 January 2021, the number of new infections, hospital admissions and deaths were higher than it ever was before since the first case was recorded in the country in March 2020.

A total of 190 000 new COVID-19 cases were recorded between 1 January and 13 January 2021, and there were approximately 4 600 COVID-19 related deaths. As at 13 January 2021, there were approximately 15 000 people with COVID-19 in hospitals, nationally, which placed a considerable strain on health facilities, personnel and equipment. Approximately one third of all COVID-19 patients in hospitals were utilising oxygen.

Dr K Cloete, Head of the Provincial Department of Health, briefed the Committee on the efficacy of the Adjusted Regulations announced on 28 December 2020. By reinstituting the alcohol ban on 28 December 2020, there was a significant reduction in trauma cases. There was a 47% reduction in trauma cases from the previous week before the alcohol ban was reinstated, and a 58% reduction in cases in the peak if one compares New Year's Day to Boxing Day. If one compared New Year's Day in 2020 to New Year's Day in 2021, there was a 65% reduction in trauma cases for all emergency centres across the country.

Dr H Malila, Director-General for the Department of the Premier, informed the Committee that the prohibition on the sale of alcohol has been very effective in reducing trauma cases in the five key hospitals in the Province, and by extension, all health facilities in the Western Cape. There were approximately 77 COVID-19 related matters that were forwarded to the Liquor Licensing Tribunal, which resulted in three licenses being revoked, five dismissals of applications, four matters where the licensee was issued with stricter conditions, six suspensions of licenses, one cancelled license, 27 fines, and 30 matters were still pending.

The Premier indicated that the preferred approach to implementing Regulations or lockdowns would be to take a differentiated approach going forward i.e. implementing different levels of regulations or lockdowns for different areas depending on the severity of the COVID-19 situation in those areas. Major lockdowns had a major impact on the economy, therefore the differentiated approach was preferred going forward. The country could not afford to continue with the blanket implementation of Regulations or lockdowns. Shorter interventions were needed so that less harm was inflicted on the economy.

More business support packages were needed during lockdowns, as many businesses were closing their doors because of the lockdown Regulations and were unable to re-open as they could not pay salaries and bonds, or repay loans.

Closing beaches during the lockdown had an impact on the oceans economy, from the vendors and fishmongers, to the restaurants and hotels. This is a massive industry where many business owners were impacted in terms of not being able to generate an income during the height of the tourism season, which would have sustained them, financially, for the rest of the year. Therefore, it was critical to push for further Unemployment Insurance Fund and other businesses support programmes.

The Premier indicated that extra hospital beds were supplied to health facilities across the Province. These were permanent beds that would be utilised for other purposes post the pandemic.

There were certain areas of the Province that showed less steep curves in terms of infections, which indicated that there was a certain amount of immunity emerging in some communities.

8.2. 04 March 2021: Briefing by the South African Health Products Regulatory Authority (SAHPRA) on the regulatory environment pertaining to vaccines in general and the COVID-19 vaccine

South African Health Products Regulatory Authority (SAHPRA) is a Section 3A public entity that was formed by the South African government to oversee the regulation of health products which includes medicines, medical devices, in-vitro diagnostic tests and devices, radiation emitting products and devices used in health care and industry. SAHPRA replaced the Medicines Control Council (MCC) as well as the Directorate of Radiation Control (DRC).

Vaccine application requirements

Prior to the approval of any vaccine, all information on the vaccine must be established. All lab based data is monitored as per the available data on the vaccines performance. Ongoing data is received in batches for review. Evaluation reports is generated for the outcome of each review.

Registration of medicine

The Johnson and Johnson vaccine was at an advanced stage of review. Government is in a position to access any other vaccine which was not under a clinical study. Despite Section 21 being for emergency use, it meant government could procure it to be able to implement it into the different phases, if the quantities authorised were insufficient. The applicant could request for the quantities to be increased. Any new product developed still had to undergo clinical trials to generate sufficient data to make sure it met the correct requirements. Vaccine registration is done in terms of Section 15(6a) of the Medicines and Related Substance Act 101 of 1965, which allows SAHPRA to register a medicine, subject to certain conditions.

Utilisation of Ivermectin

The Pretoria High Court issued a court order pertaining to four cases that were brought against SAHPRA and the Minister of Health regarding access to Ivermectin for use in COVID-19 treatments. The court order was as a result of settlement agreements reached between SAHPRA, the Minister of Health and the applicants in the four cases. A National Advisory Committee reviewed the evidence and data pertaining to the utilisation of Ivermectin as a potential vaccine. SAHPRA advised that there is insufficient scientific evidence on the efficacy of Ivermectin for the prevention or treatment of COVID-19. Continued monitoring would be conducted on emerging data regarding the use of Ivermectin for the treatment of COVID-19. SAHPRA had received no application for the registration of an Ivermectin-containing medicine for COVID-19.

Utilisation of resources

The total staff complement was approximately 450. However, at the time, the entity was running with a staff complement of about 280. While the entity was understaffed, it was not only putting mechanisms in place to recruit employees, but was also working on raising funds from National Treasury to be able to fully capacitate the Organisation. A big challenge faced during the COVID-19 period was other areas of work could not be neglected. The entire SAHPRA team was working non-stop since the start of the pandemic.

8.3. 03 September 2021: Briefing by the the Department of the Premier on the Western Cape Government's communication with residents on: general information relating to the COVID-19 pandemic, behaviours to limit the spread of COVID-19, safety of COVID-19 vaccines, vaccine registration and availability, and information and misinformation on this virus.

Briefing by the COVID-19 Actuaries Response Group on its core business of communicating on the pandemic. They were also requested to brief the Committee on the collaboration of actuaries and how it came about, the information and education strategies, the Group's responses to the pandemic, particularly in SA and insights on information and misinformation on the virus.

Briefing by the Twitter influencers Dr. Ridhwaan Suliman and Mr. Sugan Naidoo on social media information sharing during the pandemic as well as the drivers that led to them becoming COVID-19 information influencers. They were also requested to discuss important lessons learned over the past 18 months with regards to communicating, information and misinformation on this virus.

Presentation by the Department of the Premier

Ms. F Steyn, Head Corporate Communications: Department of Health briefed the Committee on the Western Cape Government's COVID-19 communication campaign. She indicated that the first positive COVID-19 case in the Western Cape was confirmed on 11 March 2020. This led to an immediate activation of the provincial Outbreak Response Team which was established to deal with all COVID-19 incidents.

Weekly digital press conferences were and continued to be held on issues related to COVID-19, vaccination roll-out plans and updates on the various waves. As part of the Communication drive, a dedicated COVID-19 website and Vaccination Dashboard was established to provide current information on the province's response to the pandemic and on the safety and efficacy of the vaccine.

As part of the COVID-19 third wave and vaccination communication, Premier Winde conducted radio shows e.g. Community Safety Radio Show: Simulcast from Radio Zibonele and Radio Helderberg (Khayelitsha Hotspot Communication). This took place on the 1st Thursday of each month, between 18:00pm – 19:00pm. The show is interactive and dealt with various topics related to COVID-19. Six radio advertisements in all three official languages were produced from 7 June 2021 to 31 July 2021. Further hereto, Community Safety Radio shows were held as part of the awareness drive and was still being aired. Members of the public were also urged to utilise social platforms to raise questions and communicate with the Department of the Premier should they require more information on the subject matter.

Print newspapers in all three official languages were also utilised as part of the drive to affect behavioral change. These adverts reminded citizens to stay safe by adhering to the usual regulations i.e. wearing a mask, sanitising, keeping a safe social distance, keeping gatherings outside and being extra cautious if they had comorbidities. The print publications included George Herald, Knysna Plett Herald, Mosselbay Advertiser, Oudtshoorn, Courant, Athlone News, Bolander, Plainsman, Vukani, False Bay Echo, Ons Kontrei, Impact News, Isolabantu, Karoo Stem, Swartland Joernaal, Witzenberg Herald, Dizindaba, Tygerburger, People's Post, Die Hoorn, Paarl Post, Eikestadnuus, Helderberg Gazette, District Mail, Swartland Gazette, Weslander, Hermanus Times, Breederivier Gazette, Worcester Standard, City Vision – Khayelitsha, Lagunya and Lwandle/Nomzamo.

Areas that were identified as hotspots received special attention in the form of simulcast, bi-weekly radio shows on two community radio stations (Radio Zibonele and Radio Helderberg), which focused on vaccine hesitancy and the importance of getting vaccinated. The Community Safety Department's Campaign focused on the Eastern Substructure and Khayelitsha region and commenced in April 2021 and ran until January 2022.

Through the utilisation of social media platforms, the Department of the Premier was able to reach a total of 738, 210 people. The purpose of the campaign was to educate and create awareness about the importance of flattening the curve. Facebook proved to be an effective platform for the type of content produced. Over 60% of the content created for the campaign was in isiXhosa and Afrikaans. The English language posts turned out to be the preferred posts.

Premier Winde also provided input on the subject matter. He indicated that professors and doctors remained the best source of information on the pandemic. The Communication Strategy of the Western Cape Provincial Government had been informed by advice from medical experts. He stated that the Western Cape Government COVID-19 dashboard contained all the relevant information and statistics tracking virus prevalence in communities. It also focused extensively on the prevalence of fake news and also dealt with "Frequently Asked Questions". He indicated that the province's COVID-19 Task Team was assisted by the Premier's entire research component to ensure that information on COVID-19 was broadcasted to all persons in the Western Cape as a means of eradicating stigmatisation of the vaccine in communities and to urge residents to get vaccinated. Areas with high hesitancy rates were identified and were targeted for awareness campaigns. These programmes looked at why there was a hesitancy to vaccinate and addressed those reasons. Collaborations with religious leaders like Archbishop Desmond Tutu were formed as part of the drive of creating awareness to combat the rapid spread of the virus. Individual reports also highlighted the impact of social media. Learners played a pivotal role in the transmission of information to their grandparents.
Local government was also tasked with the same directive. The Coronavirus Task Team consisted of diverse participants from government, civil society and business. The weekly digital press conference presentations had assisted with risk mitigation. Members from across the political spectrum were applauded for supporting the Western Cape Governments (WCPG) Awareness Programme by communicating and sharing it with their constituents. He indicated that in Du Noon, video content had been the medium of choice as their COVID-19 combat strategy. The West Coast municipalities opted for the loud hailing medium and in the Overberg region, each municipality had their own dashboard that contained pertinent information on how many residents had registered and how many had been vaccinated.

Vaccine registration and vaccine availability

There were ongoing debates on the efficacy of Ivermectin and Dexamethasone for the treatment of the coronavirus. Attempts to initiate trials had been strongly refuted by universities as well as the medical fraternity.
The Premier informed the Committee that he was aware of the social media content distributed by Dr Susan Vosloo. He indicated that the WCG reacted to the video immediately. He stressed that doctors were the best communicators on the pandemic, but they could not be the only communicators on the pandemic. According to healthcare data, doctors were the highest utilisers of the vaccine. He indicated that he would be worried if doctors were hesitant to take the vaccine but they were not. The WCG tried all the available alternatives and championed transparency and openness in dealing with the coronavirus response. Dr Saadiq Kariem, the Acting Head of the Department of Health, corroborated the Premier's statement about the WCG's response to misinformation that had emanated from registered medical practitioners statements regarding the vaccine.

Concern

A concern was raised by one of the Members about the possibility of making the vaccination mandatory. The Premier indicated that the COVID-19 vaccine had not been made mandatory and that it was still the individual's choice to be vaccinated. He expressed his concern regarding claims that children were being coerced to be vaccinated when the option was not made available to children.

Findings

Discovery had made it mandatory for its staff to be vaccinated. Discussions were held regarding the WCG stance on mandatory vaccination for its staff. The Premier indicated that other countries

had already instituted mandatory policies. Discussions about a mandatory policy had gained momentum in all spheres of society and businesses. He elaborated on the utilisation of an e-passport for international travel as the vaccine certificate was deemed to be insufficient. Discussions were being held at national level to institute the Electronic Vaccination Data System linked as a quick response code to an individual's mobile phone to ensure connectivity even when traveling.
Businesses had started to provide incentives to promote the utilisation of the vaccination. Game Stores provided a discount to customers who were able to produce their vaccine certificate as a means of protecting the economy and frontline workers.

Presentation by the COVID-19 Actuaries Response Group

The COVID-19 Actuaries Response Group (the Group) briefed the Committee on its core business. Discussions were held on the Group's collaboration with other actuaries and how it came about. Mr Stuart McDonald, Co-founder of the Group, provided a brief outline about the formation of the voluntary group, its activities and successes since its inception. He indicated that the COVID-19 Actuaries Response Group was formed in early March 2020 by several individuals who had become very concerned about the spread of the virus.
The Group comprised of 16 members which included medical experts, actuaries with epidemiological backgrounds and catastrophists. The aim of the Group was to serve as a forum to learn, educate, inform and influence information on the COVID-19 crisis constructively. The Group would dispense rapid, credible information on the virus while disseminating short bulletins on the pandemic. Information was gathered on COVID-19 and utilised for research modelling to gather statistics on excess deaths, hospitalisation cases, and evidence about future waves and death projections. This was to provide awareness on the virus and to address longevity, mortality, epidemiology and medicine. Actuaries, epidemiologists and longevity specialists gathered to speak out to clear up/combat misinformation. The main objective was to provide factual unbiased information about the vaccine. Social media and main stream media platforms were utilised to promote actuarial data to further combat misinformation. The benefits of vaccines were tracked and the mathematics simplified for the average person to comprehend that unvaccinated people are more susceptible to contracting the virus which could lead to hospitalisation and possible death, as opposed to those who had been vaccinated.
Mr Louis Rossouw, Group Head of Research and Analytics, provided a brief synopsis from a South African perspective about the benefits of an early lockdown. He reported that the South African Government's response to the pandemic was derived from statistics obtained from other countries' response to the pandemic. A slow inadequate response to the outbreak would have resulted in catastrophe. Internationally the slow response to the virus resulted in a higher death rate, whereas in South Africa the death rate at the time was relatively low in comparison. Data warehouses were set up which provided guidance on how to approach emergent variants and risk mitigation. The coronavirus mutates less rapidly than the flu virus although it seems the immunity from vaccines wane more quickly which prompted further discussions on the need for frequent boosters.
He informed the Committee that booster shots would have to be administered as an additional protection against variant variations to boost the initial shot. He also indicated that to avoid the emergence of further variants from infecting more people equitable vaccination distribution should transpire. Herd immunity can only be achieved if the vaccine ratio administered matches the total population. Current bias against the vaccine prevents people from taking the vaccine, therefore openness and transparency is required to dispel the misinformation. Once the endemic stage is reached with a combination of booster shots and public awareness, a semblance of normality might be achieved. Behavioural changes e.g. wearing masks in public spaces, wearing masks in public transport, washing and sanitising hands and rescheduling certain mass events from winter to summer months could also become permanent ways of combating future variants.

In conclusion a group of actuaries who contributed its efforts to deal with the COVID-19 pandemic were awarded the Judges' Award for their contribution to the industry. Their research and analysis was all done voluntarily, shared freely and was showcased as the risk management and modelling skills of actuaries.

Concerns

South Africa has advanced genomic sequencing capabilities, which allows it to detect new variants relatively quickly. Concern was raised that, because of this capability, South Africa was labelled as the origination of the variant, rather than the first to identify it, which resulted in South Africa being red-listed, perhaps unfairly.
The Group admitted that combating disinformation was challenging. They stated that there are two types of disinformation namely the sceptics and the alarmists. The Group engages with sceptics by providing factual information that nullifies the outcry. Rather than focusing on the extremes, the Group suggested the uncertainty around those assumptions be reviewed. Things were not always as bad as they seem. It was challenging as a small volunteer group to mitigate alarming messages of big media, but they indicated that there had been some successes.

Presentation by Twitter influencers Sugan Naidoo and Ridhwaan Suliman

Dr Ridhwaan Suliman, Senior Researcher at Council for Industrial and Scientific Research (CSIR), spoke in his personal capacity about his experience on tracking and communicating about Covid-19 trends on social media platforms. He stated that he mainly shares analysis and trends but also engages with other groups to receive information on COVID-19 e.g. the National Policy Data Observatory, the MAC technical working group and views regular interviews and updates posted in the media. He indicated that utilising data to counteract fear, uncertainty, misinformation and conspiracy theories dispels any concept for misinformation and conspiracy theories. He creates graphs by using applied mathematics and reliable data sources on the pandemic to promote simple, clear, accurate and unbiased information on COVID-19.
There are a lot of reliable sources available. The Western Cape dashboard was listed as a useful tool to find information on COVID-19 and to ask pertinent questions pertaining to the virus. He informed the Committee that access to provincial test numbers shared on a daily basis would be useful. The Western Cape made these statistics available via the provincial dashboard but it needs to be done for each province. He suggested reporting data by specimen date, rather than reporting solely on the date is useful in understanding trends such as testing and COVID-19 deaths. He advised the Committee that simple and clear messaging, consistent and accurate reporting would gain public trust. He also indicated that to have the data downloadable would be useful.
Mr Sugan Naidoo, High School Teacher and COVID-19 Influencer, informed the Committee that collating information on COVID-19 proved to be challenging as the available information did not adequately portray information on new infections and new deaths. Previously everything was done manually but improvements have since been made. The National Institute for Communicable Diseases had since made some Excel spreadsheets available. However, not all Excel and CSV files were made available on the public forum.
He advised that the time utilised on sharing COVID-19 related information varied as it depended on the availability of information that he collated to report on. The preparation and collation of information for media and radio interviews are time consuming and could take up to 20 to 30 hours a week during waves and minimum of an hour to two hours per day to collate. This he indicated, is due to the fact that the information needs to be researched and carefully notarised prior to it being disseminated on social media platforms.
He stated that as a teacher, he understands that scientific data can be difficult to comprehend. It becomes overwhelming for students who do not fully understand how to read and unpack the

data received. He raised his concern about teacher training being inadequate. He advised that being educated on data, numbers and statistics from a foundation level could be beneficial for all as we are living in an era where data and statistics are always used. This would require more science graduates apply into the teaching profession which would in turn strengthen the South African education system.

9. Government Finance and Budgets

9.1. 03 February 2021: Briefing by the Minister of Finance and Economic Opportunities and the Provincial Treasury on funding for the vaccine.

The Minister Finance and Economic Opportunities, Mr D Maynier, acknowledged the challenging task that lies ahead for the Provincial Treasury in the vaccines roll out. He informed the Committee that the rough cost estimate for vaccination in the province amounted to R1.7 billion. Ensuring sufficient funding for vaccines is the top priority for treasury at the moment.

The Minister stated that currently there is significant uncertainty around the demand and supply forecasting of vaccines as well as the finance options available. The Provincial Treasury was in conversation with the National Treasury at the technical level and was waiting for further information on the financing of the vaccine roll out. He added that the Provincial Treasury was concerned that the national government may not allocate sufficient funding to the province. So Provincial Treasury was proactively exploring other available options such as budget reprioritisation, utilising provincial reserve and mobilising the private sector for resources. Once the budget process at both the national and the provincial levels had been concluded, more information around the financing of the vaccines would become available.
Mr D Savage, the Head of Department for Provincial Treasury, informed the Committee that this COVID-19 vaccination was an unprecedented exercise. He reminded the Committee of the confined fiscal environment at large. There was significant budget reduction driven by the new national strategy for the public sector's compensation and non-compensation expenditure.

Dr Roy Havemann, Deputy Director-General: Fiscal and Economic Services for Provincial Treasury, briefed the Committee on the cost of vaccines. At the moment, a single dose was estimated at R2.33 and this amount doubled for a two-dose vaccines. R231 was the estimated administrative cost per person related to the vaccines. He stated that each item would be carefully calculated by the treasury and there was a specific methodology in place in the rolling out of vaccines. There were also upfront payments such as building vaccination centres. All these made it crucial for provincial treasury to ensure that there would be sufficient budget to cover the 5.1 million people across sectors in the province. The estimated cost for the entire vaccine roll out was between R1.2 to R1.7 billion. The Department was also reviewing methods to recoup some of the costs, such as utilising medical aid, etc. He assured the Committee that the provincial treasury was working closely with the national government to ensure that sufficient budget was available for the vaccine roll out. In addition, provincial treasury was also monitoring the types of vaccine arriving in the country.

10. Recommendations

The Committee RECOMMENDS that each standing committee deals with matters pertaining to COVID-19 in their respective portfolios. The Committee also recommends that the Standing Committee on Health, as part of its programme, must schedule regular updates by the Department of Health on COVID-19.

The Committee reports that it has concluded the task allocated to the Ad-hoc Committee on COVID-19 by the Speaker of the Western Cape Provincial Parliament.

11. Concluding remarks

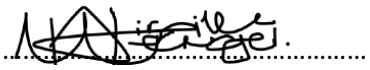
Since our last report, several new variants have emerged in South Africa: Beta, Delta, Omicron and now the emergence of Omicron sub-variants which are driving increasing case numbers. The Provincial Parliament has a responsibility to share information and provide a forum for public discussion on the way this virus is developing and the development of vaccines and treatments and to be relevant and public-focused as we face unique challenges to our collective well-being.

This pandemic has shown that when the world works together, great things can be achieved, such as the development and distribution of COVID-19 vaccines in record time.

And even though we may feel fatigued, we need to continue our focus on protecting the most vulnerable in society, learning to live our lives with COVID-19 as a part of that life, and getting our economy back on track.

The Committee extends its sincere gratitude to the health care workers who tirelessly and endlessly put service above self to help and treat COVID-19 patients and vaccinate residents at record speeds. The Committee further extends its gratitude to all sectors of government and society for the individuals that innovated, adapted, assisted to ensure that we could continue in uncertain times.

Report to be considered.



Ms MM Wenger, MPP
Chairperson of the Ad Hoc Committee on COVID-19

12. Postscript:

Planning for the future - will COVID-19 become endemic?
A note from the Western Cape Department of Health

It is anticipated that SARS-CoV-2 will continue to mutate to optimize its "fitness" (ability to infect people) by becoming more transmissible and/or having better immune escape capacity (ability to cause infection in those who already have immune responses due to prior infection and/or vaccination). These mutations could result in a virus that inherently causes either less severe disease (as occurred with Omicron which had substantial capacity for immune escape, was more transmissible than previous variants, but less virulent) or more severe disease (as occurred with Delta, which was more transmissible and more virulent than previous variants).

It is very difficult to make predictions about how SARS-CoV-2 will evolve, especially in the context of the constantly shifting immune landscape as both vaccination and infection with new variants expands. For example, ~90% of a convenience sample of adults in the Western Cape had anti-SARS-COV-2 anti-spike antibodies before the Omicron-driven fourth wave, indicating immunity from prior infection and/or vaccination. Because of these high levels of immunity, a variant would need to have immune escape to cause a substantial surge in infections. Even with an immune escape variant, some protection against severe disease is likely to be maintained, so experts believe the severity of future waves of COVID-19 is likely to be muted. Nonetheless, a highly transmissible immune escape variant could still cause substantial morbidity and mortality, especially if there is waning in protection conferred by prior infection or vaccination, or if the variant is more virulent.

Given the ongoing evolution of SARS-CoV-2 in the context of a shifting immune landscape, expert opinion is that COVID-19 waves of infection will continue until it is no longer possible for a new variant to "do better" than previous variants in spreading and escaping immunity, and it could thus take a few years before the pandemic is deemed to be over and COVID-19 is considered endemic.10 In addition to how quickly and effectively the virus evolves, the impact of such future COVID-19 waves will depend on how well our immunity holds up in the long term, hence the importance of vaccination as a cornerstone of the COVID-19 response, with an emphasis on ensuring adequate coverage of booster vaccinations in those most at risk of severe disease (older individuals or those with immune compromise).

Wadman M. When is a pandemic over? Science. 2022.
https://www.science.org/content/article/when-pandemic-over.

While the Department of Health will continue to remain vigilant of COVID-19 cases and have an agile health service response, the approach to future COVID-19 waves, as for the fourth wave, will be to focus on mitigation of a resurgence should it result in an increase in hospital admissions or deaths. Should there be an increase in admissions with severe COVID-19 disease (rather than people admitted for other reasons with an incidental COVID-19 diagnosis) we will need to act with urgency to ensure that our response is timeous, informed and appropriate to the level of risk, with adequate capacity to provide health care for those that need it. Genomic surveillance to ensure rapid identification of the variants causing COVID-19 infections and rapid epidemiological assessment of their impact is essential to inform this response.

13. ANNEXURES

- **Annexure A:**

ATC 14 April 2020 - Establishment of Ad Hoc Committee on COVID-19 and Membership
ATC 16 April 2020 - Revised Membership
ATC 20 April 2020 - Election of Chairperson
ATC 25 May 2021 - Revised Membership
ATC 15 March 2022 – Revised Membership

- **Annexure B:**

List of Disaster Management Regulations relating to the COVID-19 pandemic

- **Annexure C:**

Report of the Standing Committee on Finance, Economic Opportunities and Tourism on the COVID-19 Temporary Employer/Employee Relief Scheme (TERS)

- **Annexure D:**

National Command Council reports

- **Annexure E:**

Western Cape Education Department's interventions

- **Annexure F:**

Department Social Development strategy on dealing with COVID-19

- **Annexure G:**

Disaster intervention by District Municipalities on COVID-19

- **Annexure H:**

Western Cape Provincial Parliament Research Report

- **Annexure I:**

Media coverage

ANNEXURE A

PARLIAMENT OF THE PROVINCE OF THE WESTERN CAPE

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ANNOUNCEMENTS, TABLINGS AND COMMITTEE REPORTS

==========

TUESDAY, 14 APRIL 2020

ANNOUNCEMENT

The Speaker:

Establishment of an ad-hoc committee by the Speaker in accordance with Standing Rule 119(1)(b) with the following assignment:

To perform oversight over the work of the provincial executive authority as it responds to the COVID-19 pandemic, including oversight over any part of the provincial executive authority, any provincial department, any provincial organ of state and any provincial entity involved in activities dealing with the pandemic.

After consulting all seven (7) political parties represented in the Western Cape Provincial Parliament and all input considered, it has been resolved that the committee shall consist of fifteen (15) Members, as follows:

- Democratic Alliance: Eight (8) Members (Hon R I Allen, Hon D America, Hon D M Baartman, Hon G Bosman, Hon D G Mitchell, Hon W F Philander, Hon A P van der Westhuizen, Hon M M Wenger; Alternates: Hon L J Botha, Hon R D MacKenzie, Hon L M Maseko)
- African National Congress: Three (3) Members, but elected not to participate
- Economic Freedom Fighters: One (1) Member (Hon M Xego)
- Other smaller opposition parties: Three (3) Members jointly (Hon B N Herron [GOOD], Hon F C Christians [African Christian Democratic Party], Hon P J Marais [Freedom Front Plus], Al Jama-ah elected not to participate)

The ad-hoc committee shall have all the general powers conferred upon committees in accordance with the Standing Rules (Rule 91), as well as any other power, where applicable, conferred upon committees generally in accordance with the Standing Rules (Rules 77–95).

The Committee shall meet by way of electronic means until such time as the spread of the virus has been adequately contained so as to render in-person meetings safe.

The Committee is instructed to report regularly on its findings.

PARLIAMENT OF THE PROVINCE OF THE WESTERN CAPE

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ANNOUNCEMENTS, TABLINGS AND COMMITTEE REPORTS

==========

THURSDAY, 16 APRIL 2020

ANNOUNCEMENT

The Speaker:

Updated list of ad-hoc committee membership **(* denotes a change)**

Establishment of an ad-hoc committee by the Speaker in accordance with Standing Rule 119(1)(b) with the following assignment:

To perform oversight over the work of the provincial executive authority as it responds to the COVID-19 pandemic, including oversight over any part of the provincial executive authority, any provincial department, any provincial organ of state and any provincial entity involved in activities dealing with the pandemic.

After consulting all seven (7) political parties represented in the Western Cape Provincial Parliament and all input considered, it has been resolved that the committee shall consist of fifteen (15) Members, as follows:

- Democratic Alliance: Eight (8) Members (Hon R I Allen, Hon D America, Hon D M Baartman, Hon G Bosman, Hon D G Mitchell, Hon W F Philander, Hon A P van der Westhuizen, Hon M M Wenger; Alternates: Hon L J Botha, Hon R D MacKenzie, Hon L M Maseko)
- *African National Congress: Three (3) Members, (Hon C M Dugmore, Hon P Z Lekker, Hon R Windvogel; Alternates: Hon N G Nkondlo, Hon M K Sayed, Hon D Smith)
- Economic Freedom Fighters: One (1) Member (Hon M Xego)
- Other smaller opposition parties: Three (3) Members jointly (Hon B N Herron [GOOD], Hon F C Christians [African Christian Democratic Party], Hon P J Marais [Freedom Front Plus], Al Jama-ah elected not to participate)

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The Committee shall meet by way of electronic means until such time as the spread of the virus has been adequately contained so as to render in-person meetings safe.

The Committee is instructed to report regularly on its findings.

PARLIAMENT OF THE PROVINCE OF THE WESTERN CAPE

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ANNOUNCEMENTS, TABLINGS AND COMMITTEE REPORTS

==========

MONDAY, 20 APRIL 2020

ANNOUNCEMENTS

The Speaker:

- **Referral of document to committee in terms of section 54(1) and (2) of the Financial Management of Parliament and Provincial Legislatures Act, 2009 (Act 10 of 2009), as amended:**

  Parliamentary Oversight Committee

  Western Cape Provincial Parliament – Monthly financial statements (In-year Monitoring Report) for the period ended 31 March 2020.

- **Ad-hoc Committee on COVID-19**

  Ms M M Wenger has duly been elected as the chairperson of the Committee with effect from 17 April 2020.

TABLING

The Speaker:

Tabling of document in terms of section 54(1) and (2) of the Financial Management of Parliament and Provincial Legislatures Act, 2009 (Act 10 of 2009), as amended:

Western Cape Provincial Parliament – Monthly financial statements (In-year Monitoring Report) for the period ended 31 March 2020.

PARLIAMENT OF THE PROVINCE OF THE WESTERN CAPE

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ANNOUNCEMENTS, TABLINGS AND COMMITTEE REPORTS

==========

TUESDAY, 25 MAY 2021

ANNOUNCEMENT

The Speaker:

Changes to the membership of the Democratic Alliance in the ad-hoc committee with effect from 25 May 2021.

Honourable L J Botha is added as a permanent committee member and Honourable D G Mitchell is removed as a committee member.

ANNEXURE B:

List of Disaster Management Regulations relating to the COVID-19 pandemic

(Extracted from https://www.gov.za/covid-19/resources/regulations-and-guidelines-coronavirus-covid-19)

REGULATIONS

Core Lockdown Regulations:

- Regulations in place with lifting of National State of Disaster, 4 April 2022
- Alert level 1 adjusted lockdown regulations, 30 September 2021 as amended on 22 March 2022
- Alert level 2 adjusted lockdown regulations, 12 September 2021
- Alert level 3 adjusted lockdown regulations, 25 July 2021 as amended on 30 July 2021
- Alert level 4 lockdown regulations amendment, 29 June 2021
- Alert level 4 adjusted lockdown regulations, 27 June 2021
- Alert level 3 adjusted lockdown regulations, 15 June 2021 as amended on 17 June 2021
- Alert level 2 adjusted lockdown regulations, as amended on 30 May 2021
- Alert level 1 adjusted lockdown regulations, as amended on 22 Apr 2021
- Determination of adjusted alert level 1, 28 Feb 2021
- Alert level 1 lockdown regulations, as amended on 24 Dec 2020
- Alert level 4 lockdown regulations, 29 Apr 2020
- Lockdown regulations, as amended on 20 Apr 2020
- Lockdown regulations amendment, 20 Apr 2020
- Lockdown regulations amendment, 16 Apr 2020

DIRECTIONS

- Amended directions for Home Affairs services, 21 Apr 2022
- Directions: Full time return of learners to schools and measures to address, prevent and combat the spread of Coronavirus COVID-19 in the Education Sector, 4 Apr 2022
- Directions: Establishment of a COVID-19 Vaccine Injury No-Fault Compensation Scheme, 4 Apr 2022
- Amended directions for Sport, Arts and Culture, 1 Apr 2022
- Extension for validity period of Learner's Licences, Driving Licence Cards, Licence Discs, Professional Driving Permits and Registration of Motor Vehicles, 1 Apr 2022
- Withdrawal of directions for National Environmental Management permits and licences, 22 Mar 2022
- Taxi relief fund towards impact of Coronavirus COVID-19: Amendments, 2 Mar 2022
- Amended directions for full time return of learners to schools, 6 Feb 2022
- Amended directions for closing and re-opening of schools, 14 Jan 2022
- Amended directions: Marking examination scripts of examinations, 9 Dec 2021
- Taxi relief fund towards impact of Coronavirus COVID-19, 2 Dec 2021
- Withdrawal of directions in the biodiversity, waste, freshwater and marine fishing sectors, 28 Oct 2021
- Amended Alert Level 1 air services directions, 22 Oct 2021
- Amended directions for closing and re-opening of schools, 22 Oct 2021
- Amended directions relating to social development, 11 Oct 2021
- Amended directions for Home Affairs services, 28 Sept 2021

- Amended directions of extension validity period of learner's licences, driving licence cards, licence discs, professional driving permits and registration of motor vehicles, 31 Aug 2021
- Directions: Temporary Financial Relief Scheme for destroyed, affected or looted workplaces, 10 Aug 2021
- Amended directions relating to social development, 3 Aug 2021
- Amended directions for Sport, Arts and Culture, 2 Aug 2021
- Amended directions for re-opening of schools in 2021, 1 Aug 2021
- Amended directions for courts, court precincts and justice service points, 30 Jul 2021
- Directions on correctional centres and remand detention facilities, 21 Jul 2021
- Temporary Employee/Employer Relief Scheme (TERS) benefits for certain categories of employees, 20 Jul 2021
- Amended directions for Sport, Arts and Culture, 19 Jul 2021
- Amended directions for courts, court precincts and justice service points, 16 Jul 2021
- Amended directions relating to biodiversity sector, 16 Jul 2021
- Amended directions for re-opening of schools in 2021,15 Jul 2021
- Small Business Development directions, 15 Jul 2021
- Amended directions relating to social development, 9 Jul 2021
- Amended information and communications technology regulations, 7 Jul 2021
- Amended directions for Sport, Arts and Culture, 6 Jul 2021
- Amended directions relating to biodiversity sector, 5 Jul 2021
- Amended directions for Home Affairs services, 30 Jun 2021
- Amended Adjusted Alert Level 4 directions for Basic Education, 29 Jun 2021
- Directions for re-opening of schools in 2021, 28 May 2021
- Directions for re-opening of schools in 2021, 23 Apr 2021
- Temporary Employee/Employer Relief Scheme (TERS) benefits for certain categories of employees, 20 Apr 2021
- Amended information and communications technology regulations, 31 Mar 2021
- National framework and criteria for management of 2021 Academic Year in public and private higher education institutions, 29 Mar 2021
- Amended directions for re-opening of schools in 2021, 27 Mar 2021
- Amended directions for Home Affairs services, 26 Mar 2021
- Amended public transport services Alert Level 1 directions, 25 Mar 2021
- Amended railway operations Alert Level 1 directions, 25 Mar 2021
- Amended health directions - disposal of mortal remains, 19 Mar 2021
- Amended Alert Level 1 air services directions, 1 Mar 2021
- Amended directions relating to social grants and adoptions, 22 Feb 2021
- Directions for re-opening of schools in 2021, 12 Feb 2021
- Alert level 3 Sea Ports directions: Correction, 10 Feb 2021
- Alert level 3: Courts, court precincts and justice service points, 3 Feb 2021
- Alert level 3 Sea Ports directions, 29 Jan 2021
- Amended Cross-Border Road Transport Services Alert Level 3 directions, 29 Jan 2021
- Railway operations amended Alert Level 3 directions, 29 Jan 2021
- Amended public transport services Alert Level 3 directions, 29 Jan 2021
- Amended Alert Level 3 air services directions, 29 Jan 2021
- Directions on correctional centres and remand detention facilities, 28 Jan 2021
- Re-opening of schools for the 2021 Academic Year under Adjusted Alert Level 3, 22 Jan 2021
- Amended Adjusted Alert Level 1 directions for Home Affairs services, 14 Jan 2021
- Amended Adjusted Alert Level 3 directions for Sport, Arts and Culture, 5 Jan 2021
- Directions: Marking examination scripts of 2020 National Senior Certificate and Senior Certificate examinations, 31 Dec 2020
- Amended public transport services directions, 24 Dec 2020
- Amended health directions, 15 Dec 2020
- Amended public transport services directions, 14 Dec 2020

- Amended Alert Level 1 air services directions, 3 Dec 2020
- Amended directions of extension validity period of learner's licences, driving licence cards, licence discs, professional driving permits and registration of motor vehicles, 3 Dec 2020
- Amended Alert Level 1 sea ports directions, 3 Dec 2020
- Amended Alert Level 1 directions for Home Affairs services, 3 Dec 2020
- Amended health directions, 3 Dec 2020
- Amended electronic communications, postal and broadcasting directions, 27 Nov 2020
- Coronavirus COVID-19 Temporary Employee/Employer Relief Scheme: Withdrawal, 27 Nov 2020

OTHER LOCKDOWN REGULATIONS

- Medicines and Related Substances Act: Exclusion of Coronavirus COVID-19 vaccines from the operation of certain provisions, 15 Nov 2021
- ICT regulations, 11 Nov 2021
- Amended ICT regulations, 31 Aug 2021
- Amended ICT regulations, 28 May 2021
- Amended ICT regulations, 5 May 2020

DISASTER MANAGEMENT GUIDELINES AND NOTICES

- Disaster Management Act: Code of Practice: Managing exposure to SARS-CoV-2 in the workplace, 15 Mar 2022
- Norms and Standards for the Safer Operations of Tourism Sector in context of Coronavirus Covid-19 and Beyond, 3 Dec 2021
- Exclusion of Coronavirus COVID-19 vaccines from the operation of certain provisions, 15 Nov 2021
- Compensation for Coronavirus Covid-19 vaccination side-effects, 22 Oct 2021

DISASTER MANAGEMENT ACT

- Disaster Management Act: Revocation of the classification of the COVID-19 pandemic as a national disaster, 5 Apr 2022
- Disaster Management Act: Termination of national state of disaster, 4 Apr 2022
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 April 2022, 14 Mar 2022
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 March 2022, 13 Feb 2022
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 February 2022, 14 Jan 2022
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 January 2022, 10 Dec 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 December 2021, 13 Nov 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 November 2021, 13 Oct 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 2 will apply nationally from 1 October 2021, 30 Sept 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 October 2021, 26 Sept 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 2 will apply nationally from 13 September 2021, 12 Sept 2021

- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 October 2021, 12 Sept 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 September 2021, 12 Aug 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 3 will apply nationally from 26 July 2021, 25 Jul 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 August 2021, 12 Jul 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 4 will apply nationally on 28 June 2021, 27 Jun 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 3 will apply nationally from 00H01 on 16 June May 2021, 15 Jun 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 July 2021, 11 Jun 2021
- Disaster Management Act: Determination of Alert Level: Coronavirus COVID-19 Alert Level 2 will apply nationally from 00H01 on 31 May 2021, 30 May 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 June 2021, 14 May 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 May 2021, 14 April 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 April 2021, 11 Mar 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 March 2021, 11 Feb 2021
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown to 15 February 2021, 13 Jan 2021
- Disaster Management Act: Regulations: Coronavirus COVID-19 lockdown: Determination of alert levels and hotspots: Amendment, 29 Dec 2020
- Disaster Management Act: Determination of Coronavirus Covid-19 Alert Levels and Hospots: Garden Route, Sarah Baartman and Nelson Mandela Bay, 14 Dec 2020
- Disaster Management Act: Regulations: Coronavirus COVID-19 lockdown: Determination of alert levels and hotspots: Nelson Mandela Bay, 3 Dec 2020
- Disaster Management Act: Regulations: Alert level 1 during Coronavirus COVID-19 lockdown: Explanatory note, 3 Dec 2020
- Disaster Management Act: Extension of National State of Disaster under Coronavirus COVID-19 lockdown, 14 Nov 2020

ANNEXURE C:

Report of the Standing Committee on Finance, Economic Opportunities and Tourism on the COVID-19 Temporary Employer/Employee Relief Scheme (TERS)

(See attached report)

ANNEXURE D

Reports to the National Command Council

(See attached reports)

ANNEXURE E:

Western Cape Education Department's interventions

(See attached reports)

ANNEXURE F:

Department Social Development strategy on dealing with COVID-19

(See attached reports)

ANNEXURE G:

Disaster intervention by District Municipalities on COVID-19

(See attached reports from respective District Municipalities)

ANNEXURE H:

Western Cape Provincial Parliament Research Report

(See the attached WCPP research report)

ANNEXURE I:

Media coverage

(See attached media coverage of COVID-19)

14. List of Acronyms

CHC	**Community Healthcare Clinic**
CHW	**Community Healthcare Workers**
CTICC	**Cape Town International Convention Centre**
DSD	**Department of Social Development**
DoH	**Department of Health**
ECD	**Early Childhood Development (centre)**
GBV	**Gender based violence**
HASA	**Hospital Association of South Africa**
ICU	**Intensive Care Unit**
NGO	**Non-Governmental Organisation**
NICD	**National Institute for Communicable Diseases**
PCR	**Polymerise Chain Reaction**
PHC	**Primary Health Care**
PPE	**Personal Protection Equipment**
SASSA	**South African Social Security Agency**
SGB	**School Governing Body**
SLA	**Service level agreement**
SMME	**Small, Medium and Micro Enterprises**
TERS	**Temporary Employee/ Employer Relief Scheme**
UIF	**Unemployment Insurance Fund**
WCG	**Western Cape Government**
WCPP	**Western Cape Provincial Parliament**
WHO	**World Health Organisation**