

● WHO ARE WE?

The African Alliance is an advocacy non-profit that works to make sure underserved and ignored communities across the continent get dignified health care. We team up with a broad network of organisations across Africa to inform people about their health rights and we empower them to hold the right people to account should these rights be violated. One of the most important pillars of our operation is “co-creation”. We’re serious about advocacy projects that base their solutions on input from the affected communities.

In all our work, we take care to disrupt the traditional power structures of civil society and the public health world that have kept many African voices invisible. We believe that the Africans who contribute to public goods (such as vaccines) must also benefit from them.

● WHAT IS OUR PORTS2ARMS PROJECT ABOUT?

Ports2Arms (P2A) is a project we launched to make sure vaccines get from shipping containers at the harbour, to clinics, and then into people’s arms. It’s a tool that tracks the things that could be making it difficult for people to get their jabs, such as conflict, flooded roads or misconceptions in the community. Or, if there’s a part of the roll-out that’s working particularly well, we want to highlight that.

The goal of P2A is to gather real-time information that can be used by advocacy groups and local communities to hold the health system to account if it’s not working for them. Policy makers could also use the information to tweak their immunisation projects to suit each community’s needs.

We first envisioned this tool to be a monitoring tool for the COVID-19 vaccine roll out, and that’s what our pilot focused on in three South African provinces (Gauteng, Limpopo and Mpumalanga). But it could also work for other public health crises. We’ve tested the P2A tool in Zambia, Rwanda, Burundi, Malawi and the Democratic Republic of Congo.

● WHO IS P2A FOR?

P2A is for everyone, but it could be especially powerful for those that health systems often leave behind or alienate, including sex workers, the queer community, people who use drugs and people with disabilities.

● HOW DID THE PILOT WORK?

Our partners drew up a fortnightly report with information about stock levels, procurement, barriers to access (say, broken bridges or flooded roads etc), stories from underserved groups and a snapshot of what’s being said on local media platforms to keep track of helpful or harmful sources of information. This was shared with policy makers and civil society organisations once a month.

● WHAT DID WE LEARN FROM THE P2A PILOT IN LIMPOPO?

Existing partnerships with the provincial health department made data collection much easier, but it was still difficult to get information about stock levels. The expectations from community leaders about how involved they should be in this project also caused some problems.

● WHY PANDEMIC PLANS MUST INCLUDE COMMUNITIES

Pandemic action plans won’t work if communities aren’t involved. In the past, grassroots movements have been a crucial part of slowing the HIV and Ebola epidemics, for instance. Community action helped to reduce stigma, dispel myths about treatment, and their advocacy even resulted in lower drug prices.

We believe that collaboration with communities is the only way to serve Africa’s diverse population fairly. We won’t accept anything less.



HOW DID COVID IMPACT BLIND PEOPLE IN LIMPOPO?

Disky Lebeso is the head of the Limpopo chapter of the non-profit Blind South Africa. He’s based in Tzaneen.

Like everyone else, he says, blind folk’s lives were thrown into disarray when the national lockdowns were put in place. He says some blind people were caught off guard when they couldn’t use their usual clinics and many of them didn’t have access to the technology to help them navigate the online lockdown world (such as screen readers), Lebeso says.

There also could have been more support from community workers to make the transition easier.