The impact of C19 and the lockdown on health equity in South Africa: a context analysis for Tekano.

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BENTEC

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1. Introduction

This report describes the background, aims, methods, findings and recommendations of a research investigation into the impact of the COVID-19 (C19) pandemic on health equity in South Africa. The research was commissioned by Tekano, a non-government organisation (NGO) dedicated to health equity in South Africa. It was carried out by a team put together by Beneficial Technologies (Bentec), a Johannesburg based research consultancy. Most of the research took place between 15 July and 15 August 2020.

C19 – contagious and life threatening

C19 is a highly contagious, life threatening disease caused by the novel coronavirus, which is part of a related group of viruses known to have caused serious respiratory illnesses such as MERS[1] and SARS[2]. It was found that C19 causes mild to moderate symptoms in most people who are infected. One in five were found to require hospitalisation, mainly due to difficulties in breathing and other respiratory problems.[1] The mortality rate is thought to be between 3 and 4% of cases, although more time is needed to confirm this figure. For seasonal influenza, to which C19 is often compared, the mortality rate is 0.1%.[2]

C19 appeared in Wuhan, China in December 2019 for the first time. The World Health Organisation (WHO) declared it as a global pandemic on 11 March 2020. At the time of writing (14 August 2020), the worldwide number of cases stands at 21,176,293 and the number of deaths at 759,397.[3]

The first case was reported in South Africa on 5 March 2020. At the time of writing, the number of cases in South Africa stands at 569000 and the number of deaths at 11 010.[4]

Tekano and health equity

Tekano's vision of health equity makes reference to the Bill of Rights of the South African constitution and the Alma Ata Declaration on Primary Healthcare.[3] The organisation is supported by Atlantic Philanthropies and, in keeping with the approach of this group, Tekano works for health equity mainly through providing fellowships to leaders and activists engaged in some aspect of promoting health equity. Twenty five fellows are chosen annually for their work on the social determinants of health and they participate in a twelve month programme of mentoring, coaching and dedicated advocacy support. The idea is to foster leadership, community and collaboration that extends into a lifelong Tekano fellowship. Tekano's positioning necessitated the research and shaped its content.

[1] Middle East Respiratory Syndrome
[2] Severe Acute Respiratory Syndrome
[3] www.tekano.org.za

Why the research

As a proponent of health equity, Tekano was confronted with a pandemic threatening to cause a global health crisis. C19 struck as the second cohort of Tekano health equity fellows were completing their year long fellowship and the organisation was preparing for the start of the third cohort. There was a general sense that everything had changed and new ways of practice had to be considered. The research was commissioned to get to grips with the impact of C19 and its implications for health equity and Tekano's programmes in particular.

In line with Tekano's holistic conception of health equity and its approach of supporting health equity proponents through the fellowship, the research had to look at the impact of C19 from the perspective of health equity, while also investigating the changing terrain of leadership, activism and social cohesion where Tekano was active. Put another way, the key research questions were:

- What are the impacts of the C19 pandemic and lockdown on health equity in South Africa?
- What are the implications of these impacts for Tekano's fellowship programme?

The research process

The official starting date of the research was 15 July 2020 with the presentation of the inception report. The due date for this report was set as 15 August 2020. The relative short space of time shaped the way the research process was conceived in the following ways:

- The research team was selected on the basis that its members were already involved in C19 related research and had a head start so to speak.
- Both for reasons of time and to lower the risk of infection, it was understood that this would be mainly a desktop study relying on media and other published sources.
- It was agreed that this report will not be the final iteration. It would be followed by more research and a process of engagement between the research team and Tekano's staff and board that would culminate in a final version with recommendations for Tekano on 15 October 2020.

Two factors facilitated a major difference between the actual course of the research process and the way it was conceived. The first was that the research took place at a time when many if not most people had adapted their ways of working by shifting meetings and training from face-to-face to online. People were much more ready to be interviewed via platforms such as Zoom and WhatsApp than they were pre-Covid. The second was that we had a relatively large research team of five members. Due to these factors we were able to interview many more key informants than seemed possible when we designed the research process. Coupled with a fairly good response to our survey this meant that the study was drawing on a much greater

proportion of primary sources than was envisaged. This is an unanticipated positive for the research.

At the time of writing the research methods and sources were situated as follows:

- Documentary reviews - these included media reports, government publications, civil society statements, court records, scholarly articles, and the organisational documents of Tekano.

- Key informant interviews - we have records of 17 interviews with key informants drawn from Tekano fellows, learning partners, coaches, mentors, civil society activists, community activists and academics.

- The Tekano Survey on C19 - we sent out a total of 150 surveys to the broad Tekano network of fellows, staff, board members, partners, mentors and coaches and we received 29 responses.

As stated above all three research methods will continue after this report and the additional research will inform the final iteration.

The impact of the disease versus the impact of the lockdown

One of the key learnings from the research is the importance of the distinction between the impact of the disease and the impact of the lockdown and other measures taken in the name of responding to the disease. At this point in the development of the pandemic, there is little doubt that most of the negative impact on health equity resulted from the latter rather than the former. The lockdown did not only have negative impacts on all the elements of health equity that we investigated, but it failed in its stated objective to create time and space for the preparation of the health system and in the objective, achieved in other places, to contain the spread of the disease by bring the rate of spread[4] under control.

The emblematic imagery of this C19 pandemic and lockdown may well be a composite of poor people queueing to access services and the empty quarantine beds at the height (so far) of the pandemic in the Western Cape. The first image shows how aspects of the lockdown, such as the closure of the informal and small business sector in the townships, forced people to queue in front supermarkets, which meant the very measure taken to slow the spread of the disease resulted in people becoming exposed. The second image shows how the lack of socio-economic support made people decide not to use available services, as in this case where people chose not to enter quarantine facilities for fear of leaving their people to starve back home. This composite image of long queues and empty beds symbolises the

[4] The rate of spread of an infectious disease is measured in the basic reproduction number known as R0 or R naught. If it drops below 1, it means that on average each infected person infects fewer than 1 person and the disease will die out.[5]

counterproductive results of measures taken in the name of controlling the disease. It also symbolises the core of the story uncovered by this research.

The structure of the report

The report has the following sections:

- This introduction
- An overview of the spread of C19 through different population groups
- A review of access to critical services for the exposed and infected
- A review of state policy measures in response to Covid-19
- A discussion of socio-economic impacts including analyses of food security, housing, water, electricity and labour
- A discussion of civil society and engagement including analyses of the roles of leadership, trade unions and the private sector
- A discussion of social equity and social cohesion including specific analyses of gender equity, race equity and social cohesion
- A summary of the research findings
- A set of recommended strategic considerations for health equity proponents
- A discussion of lessons for immediate results.

We have anonymised the identities of respondents and informants. The key informant interviews are referred to by numbers 1 to 17.

2. The health impact of COVID-19

Overview of COVID-19 and its impact

At the time of writing this report, South Africa's recorded COVID-19 infections place it at number 1 globally in terms of proportion of infections to population size.[6] The first case of COVID-19 in South Africa was recorded 5 March 2020 in KwaZulu-Natal. It set in motion a period of rapid change as our government scrambled to manage the spread of the virus. Over the next few weeks the infection rate would increase steadily while the government took urgent action to respond to the impending public health disaster represented by COVID-19. On 15th of March 2020 it declared a national state of disaster and set up the National Coronavirus Command Council to develop its public health response to contain and control the spread of the pathogen that was devastating health systems all over the globe.

Given the fragile state of our public health system, lack of preventive technologies such as a vaccine that would confer protection against COVID-19 infection, and the belief on the part of government that an increase in the rate of infections could not be avoided, merely slowed down, President Cyril Ramaphosa, following the strategy adopted by countries all over the globe, announced that we would enter a national lockdown on 26th March 2020 to slow the spread of COVID-19. The lockdown shut down our economy, restricted our movements and utilised government resources to enforce the lockdown and to build the healthcare infrastructure that would be needed as the infection rate increases. It is important to note that certain sectors of the economy, e.g., export farming and the mining sector continued to operate during the national lockdown.[7] The biomedical response to COVID-19, whilst necessary at the time, placed an incredible strain on the already fragile architecture of the public resources available, while the parts of the economy it left open and the lack of effective social support threatened to undo its purpose.

At the start of the lockdown, on the 26th of March 2020, the number of confirmed COVID-19 cases was 927.[6] The highest rates of infections were concentrated in three provinces, with Gauteng registering the highest number of infections at 409; followed by the Western Cape (229) and Kwazulu Natal (134). During the period of the lockdown, the Western Cape would overtake Gauteng, becoming the epicentre of the pandemic. The early leap of the pandemic in the Western Cape was never satisfactorily accounted for. We believe it is connected to the region's status as a destination for tourists from Europe and the decision to exempt the export agricultural sector from the lockdown.

On the 1st of April testing was ramped up as the government mobilised 67 testing units and 10 000 community workers into community hotspots to conduct testing. By the 19 of April 2020 115 00 tests had been conducted, of which 3158 were positive. By the end of the 35-day lockdown on the 30th of April, 207 530 tests had been conducted, 5647 COVID-19 cases had

been recorded with 2073 recoveries and 103 deaths. It was not clear, however, what progress had been made in terms of one of the key aspects that served as the rationale for the lockdown, strengthening the health system to deal with a rapid increase in infections requiring critical care.

Nevertheless, the lockdown was judged as successful with the WHO commending the country for its quick response and actions to limit the spread of the virus and President Ramaphosa declaring that the lockdown was the most effective means of containing the spread of COVID-19. While the lockdown may have achieved positive gains in terms of containing the spread of COVID-19, it failed to stop community transmissions and specifically failed to stop it from spreading to the townships. The disease that was initially referred to as a ‘’rich man’s’’ disease carried by travellers returning from journeys abroad would exact its most devastating toll from low-income communities. In these communities, overcrowding made it impossible to stay indoors and practice social distancing. The stay-at-home order also resulted in a loss of income for many citizens living in conditions of impoverishment, leaving them food insecure and struggling to survive. People had to choose between staying at home and starving, or leave their homes to look for food while risking infection and police violence. These features of the lockdown that made its failure always likely, was visible and present from the beginning, even when it won much praise.

The lockdown, we show below, represents the antithesis to health equity in contexts of deprivation. In a country with one of the highest rates of inequality in the world, the lockdown had an additive effect; exacerbating the existing deep trenches of inequality that run through South African society. It is the poor, vulnerable and marginalised groups of South Africans who are the casualties and who bear the burden of the COVID-19 strategy. President Ramaphosa acknowledged that a lockdown could not be indefinitely sustained: “Our people need to eat. They need to earn a living. Companies need to be able to produce and to trade, they need to generate revenue and keep their employees in employment.” [8]

As lockdown restrictions were relaxed and life steadily returned to a familiar but amplified normal of deprivation and struggle, the rate of infection has continued to increase. By the 20th of July, South Africa was ranked 5th globally, with half of Africa’s overall cases recorded here. During the period 28th July to the 10th of August, South Africa recorded a staggering 106 348 new cases of COVID-19. As of the 12th of August 2020, 3 295 434 tests have been conducted, 568 919 infections have been recorded, with 432 029 recoveries and 11 010 deaths.

The rest of this chapter provides a brief overview of the health-related dynamics of COVID-19 on a number of dimensions: COVID-19 and its impact on the quadruple burden of disease; COVID-19 and comorbidities; the impact of COVID-19 on the health system and finally COVI-19 testing and contact tracing. Given the rapid pace with which the pandemic has entered the South African landscape, the available knowledge on the nature and scope of COVID-19 and its impact on the South African population is limited and evolving. This chapter does not seek to be exhaustive, but simply to provide a brief overview of these issues with the best evidence that we were able to access in producing this draft report. In further developing this chapter over the

course of the context analysis, we will incorporate emerging evidence and insights from key informants in the healthcare sector to enhance our understanding of the health impact of COVID-19

Impact of COVID-19 on South Africa's quadruple disease burden

South Africa has a quadruple burden of disease represented by four categories of diseases namely, maternal, newborn and child health; HIV/AIDS and tuberculosis; non-communicable diseases; and violence and injury (WHO, 2018). Given the limited resources and infrastructure available in the public health system, it is difficult to manage the disease burden without the threat of a pandemic. With the introduction of COVID-19 into the scenario, this threat was amplified. COVID-19 poses a direct threat to the management of the burden of disease due to the reprioritisation of health priorities to accommodate the COVID-19 disease burden. In a recent telephonic household survey to assess the impact of COVID-19 on the South Africans, Spaull et al. (2020) found that nearly 1-in-5 respondents who had a chronic condition such as HIV, TB , heart conditions or diabetes reported an inability to access their medication. Also, in this study, it was reported that of those in need of care for an acute condition, only 78% visited a healthcare facility.

Hofman and Madhi[9] outline a number of key impacts that privileging COVID-19 in the health system will have on the quadruple burden of disease. In terms of maternal and child health, a disruption in services to this target population will have a devastating impact. It is estimated that a 9-18% reduction in maternal and child health coverage over a six month period would lead to a minimum of an additional 2160 child deaths. This is in spite of the fact that children are at low risk of experiencing severe COVID-19 illness.

Secondly, the interruption of a six-month supply of ARVs to the whole population of HIV patients in South Africa could result in a 2-fold increase in HIV-related deaths over a 1-year period. This amounts to an excess of between 83 800 and 140 900 adult HIV deaths in the event of such a high level of disruption in access to ARVs. In a study conducted by Spaull (2020) 1-in-10 of HIV positive new and pregnant mothers who participated in the study reported that they had run out of ARVs in May and June.

Thirdly, in terms of the impact of COVID-19 on non-communicable diseases, diabetes and hypertension have been highlighted as key risk factors for severe COVID-19 disease that will require hospitalisation. South Africa has a high rate of type 2 diabetes of 12%; a high rate of people who fall in the obesity and overweight category, with 68% of women and 31% of men over the age of 15 fall in this category. According to Schellack et al. (2020) COVID-19 affects the management of patients with diabetes both directly and indirectly. This impact results in poorer health outcomes overall and exacerbates the multiple disease burden on the healthcare system. It, therefore, has cost implications but also strains the limited human resources allocated to delivering routine care during the pandemic.

Finally, violence and injury has consistently been cited as endemic in the South African population and we have one of the highest rates of violence against women and children globally (WHO, 2018). Violence is, therefore, a major contributor to disease burn in this country. Over the period of the lockdown a marked reduction in incidents of violence and GBV was observed. This reduction of violence was celebrated by government officials in their daily briefings and media reports. These briefings and reports did not acknowledge the ongoing police brutality and violence being committed by the police and the SANDF in communities as part of their enforcement of lockdown regulations. Following the opening of alcohol sales at the end of the level 5 lockdown, there was a surge in both intentional and non-intentional harm, which increased the pressure on the health system as victims presented at trauma centres.

Impact of COVID-19 on people living with pre-existing conditions

In the context of COVID-19, co-morbidities are defined as pre-existing chronic conditions that put people at higher risk if they are infected with the coronavirus. The co-morbidities that are most commonly implicated in higher risk of severe illness due to COVID-19 include diabetes, hypertension, lung disease, obesity, kidney diseases and HIV/AIDS. As the WHO pointed out, HIV/AIDS, TB, cancer and diabetes are serious conditions that compromise the immune system and thus patients who have these conditions, are at higher risk for developing more severe forms of COVID-19. In addition, age has also been identified as a co-morbidity, with other adults also carrying greater risk of serious illness and death due to COVID-19 (Schellack et al., 2020).

At 9th June 2020, the Western Cape province had reported the highest death rate per 100 000 inhabitants from COVID-19 (Alcorn, 2020). Data from this province shows that diabetes, hypertension and HIV are amongst the most prevalent co-morbidities where people have died of COVID-19 in this province. In addition, 65% of people who died had more than one comorbidity. In the younger age groups of 20-29 and 30-39 years, hypertension and HIV/AIDS were listed as the top co-morbidities. In the age group 50 years and older, hypertension and diabetes were listed as the top co-morbidities (Williams, 2020)

Other trends in terms of co-morbidities in the Western Cape are reported by Alcorn (2020) and include: elevated risk of death from COVID in people living with HIV; men are more likely to die of COVID-19 than women; the risk of death increases with each age band over the age of 40 years; poorly controlled or uncontrolled diabetes is also associated with a higher risk of death than controlled diabetes with this disease having a greater impact on risk of death than hypertension and chronic kidney disease; people with active TB are also two and half times more likely to die of COVID-19 than those who do not have TB.

Following a similar trend to other settings, in July 2020, provincial data in Gauteng province show that the most prevalent comorbidities in deaths here were diabetes (14% of cases), hypertension (23%) and a combination of both these comorbidities in 18% of cases. Other comorbidities reported in this province include renovascular disease (5%) and chronic obstructive pulmonary disease (5%). Notably, one quarter of the deaths in this province did not

show any comorbidities. The deaths recorded by age in Gauteng, were 66% of people who died were between the age of 59 and 79 years and mostly male. Other age groups most affected include those in the age band 40 to 49 years (10.9%) and those in the 80 to 89 age band (9.8%).

In terms of the impact of COVID-19 on mortality, in a recent report the MRC predicted that there have been 33 478 excess deaths when compared with historical data.[10] The council began to calculate excess deaths on 6 May 2020 when the death rates began to depart from the predicted level. The majority of the deaths observed (two-thirds) have occurred in the age band of 60 years and above. While the council is cautious about making decisive claims about whether these deaths are directly or indirectly related to COVID-19, they do suggest that the observed increase strongly supports a conclusion that a significant proportion of the excess mortality is likely attributable to COVID-19 (Bradshaw, 14 August 2020). An examination of the underlying causes of death will ultimately provide clarity. The council further reported that, since 4 August 2020, the excess deaths observed in all provinces have begun to plateau or decline. This trend may indicate that South Africa's COVID-19 infection rate has peaked and may signal a downturn in the epidemic.

At the start of COVID-19 pandemic, it was highlighted that this new and novel virus puts everyone at risk. Prof Abdool-Karim, in a Daily Maverick webinar stated that everyone is at risk, no matter race, gender, age, socio-economic status. While this may be true from a purely biomedical perspective, reflecting on the deaths due to COVID-19 and its impact on disease burden leads us to the conclusion that poor Black people are at higher risk than others; and that this elevated level of risk of death is not limited to co-morbidities. The factors that are implicated in the development of diseases that make up our disease burden, and that reflect the spread of these diseases in the general population, race, gender, age, socio-economic status, will highlight the fact that we are not all equally at risk of dying from COVID-19. Exposure to the gross inequalities that characterise South Africa determines our exposure and risk level.

Impact of COVID-19 on the Health System

With the declaration of a national disaster due to COVID-19, the focus of government shifted to the prevention and treatment of COVID. This focus centred around strengthening the health system infrastructure to deal with the influx of serious COVID-19 infections as the number of cases increased (Taylor et al., 2020). In this context, all elective procedures and surgeries were stopped and healthcare staff reallocated and called to the frontlines to assist with screening of patients.

Predictably, as the number of COVID-infections have increased over the various lockdown levels, COVID-related deaths and admissions have increased exponentially, requiring an intense and sharpened focus on COVID. This focus, however, has created a backlog of patients with non-COVID-19 diseases who are not able to access care, treatment or life-saving medications. As Taylor et al. (2020) describes, this shift has both supply and demand side

effects. On the supply side, the emphasis on COVID-19 has reallocated human resources, and in so doing restricted the level of service available to diagnose, treat and prevent other health issues. On the demand side, citizens who rely on the public healthcare system have not been able to access services due to the lockdown and, for example, transport restrictions.

While South African health professionals in the public health system are intimately familiar with prioritising care within severe resource restraints, the pressure on the system has been intense. In the same way as COVID-19 has amplified and deepened fractures at community level, in the spaces where the majority of South Africans live their lives, it has shown the fractures in and exacerbated pre-existing weaknesses in our already overburdened health care system. Without intervention to return to providing care to non-COVID-19 diseases, South Africa will experience increased mortality and morbidity from the existing pre-COVID disease burden.

In addition to the impact on physical resources and service provision, globally COVID-19 has also had a devastating impact on healthcare workers who perform essential work at the frontline of the pandemic. In addition to the psychological toll that caring for patients who are isolated from their families and witnessing the deaths of patients and colleagues bring, health care workers also experience physical exhaustion and elevated risk of becoming infected with COVID-19. On 13 August 2020, IOL online reported that, according to our Health Minister, the overall infection rate amongst our 27 360 health workers is 6027. The largest rate of infections in this group is recorded in the public health system, with 6027 infections (78%) in the public health system and 6027 (22%) in the private health system. Out of these infections 240 healthcare workers have died from COVID-19. The majority of these deaths, 203, occurred in the public sector, while thirty-seven of deaths occurred in the private sector. Gaps in resource capacity, especially with respect to human resources and personal protective equipment (PPE) are implicated as impacting COVID-19 amongst healthcare workers. Healthcare care workers across South Africa have protested to demand adequate access to PPE as they fight COVID-19 in the overcrowded, under-resourced healthcare system.

Have these measures been adequate? As Singh and Moodley (2020) pointed out, on 29 May 2020, Department of Health officials announced that the country's private and state sector had allocated 27 467 beds for COVID-19 patients. 2 309 of these were critical care beds. In addition, provincial and private sector hospitals were advised to double their critical care capacity by utilising theatre recovery rooms, certain theatres, treatment rooms and ward space as part of a 'surge strategy'. However, in spite of these efforts, the capacity will be inadequate if the COVID-19 predictions for South African materialise. The projected 20 000 to 35 000 ICU beds that will be required to meet the demand will simply not be available.

With the modest gains from the focus on COVID-19, Taylor et al. (2020) argues that it is not sustainable to focus exclusively on the pandemic, while other diseases remain unmanaged. It is suggested that principles of healthcare rationing and careful and considered allocation of scarce resources by priority regardless of COVID status must be implemented. This ''re-opening'' of hospitals will also be crucial as lockdown restrictions are relaxed, the alcohol ban is lifted and

the critical care sector comes under strain again due to a return to high levels of violent crime, motor-vehicle and alcohol related illnesses.

COVID-19 testing and contact tracing

When COVID-19 first emerged as a public health threat in South Africa, the use of testing as a way of isolating, treating and containing the spread of the virus was restricted due to fears that we would not have enough tests available. According to Abdool-Karim (April, 2020) this initial caution around testing resulted in a need to play catch-up in rolling out COVID-19 testing. At the start of the national lockdown in the last week of March 2020, government announced that it would roll out a large-scale screening, testing, tracing and medical management programme to manage COVID-19. During this stage government suggested that it would expand to 36 000 per day with a 24-hour turnaround time through the National Health Laboratory Service (van den Heever, 2020). In the private sector tests have consistently been conducted at a rate of 7000 tests per day. Taking this into account, it was hoped that we would reach a capacity of 43 000 tests per day by the end of April 2020.

A community screening and testing programme was also rolled out in which more than 28 000 healthcare workers were deployed into communities to conduct screening and testing.[11] The following criteria guided community screening and testing (1) presence of cases and (2) social vulnerability of community. The aim of the community screening and testing programme was to rapidly identify and isolate cases to prevent rapid spread of the virus (David, 2020).

The stated intentions and expected gains from the screening and testing programme were, however, not realised. According to Green (June, 2020) and Mendelson and Mahdi [12] the number of tests received in laboratories exceeded laboratory capacity to deliver results within 12-24 hours of sampling. This resulted in substantial backlogs, estimated at around 10 000 tests in laboratories with capacities to conduct 1000 tests per day. The delay in diagnosis resulted in large numbers of patients awaiting test results in hospital, placing strain on the healthcare system. An added complication is that awaiting test results of patients suspected of being COVID-19 positive, increases the risk of infection in overcrowded hospital wards. These problems are more acute in rural areas where the turnaround time for tests is between 14 and 20 days.

As of 10 August 2020, 3 267 494 tests have been conducted. Of these tests 56% have been conducted in the private sector, and 44% in the public sector (NICD, 10 August, 2020). Green (June, 2020) highlights disparities in testing use and turnaround time between the public and private sector. In the private sector, which serves approximately 20% of the South African population, it is argued that there is an overuse of tests. Approximately half of tests are conducted here as testing is accessible to those who are able to pay for it. Test results in the private sector are available roughly within 48 hours. In the public sector, which serves 80% of the population, healthcare workers and patients wait a week or even weeks for test results. In this context, samples may become unusable before they are tested. According to the most

recent weekly COVID-19 testing report, mean test turnaround times in the public sector went from 2.1 days in early May to 12.4 days in the week ending 13 June.

The second component of the government testing programme is contact tracing. The COVID-19 contact tracing database, conducted under the auspices of the legislatively organised national state of disaster, was established early in April 2020 (Klaaren et al., July 2020). Its primary goal is to trace and locate anyone who has had contact with a COVID-19 positive person in order to mitigate the expected surge in severe COVID-19 cases. The effectiveness of contact tracing in containing the spread of infections has been demonstrated across a number of settings, including South Korea and China (Bode et al., May 2020). Contact tracing is most effective when conducted via a digital contact tracing system. Such a platform has not been developed in South Africa. In a system where rapid notification is essential, due to a low smartphone penetration rate in the South African population (~50%), contact tracing is conducted via a slow manual process. Government has failed to explore alternatives to the smartphone technology that digital systems rely on (Georg, June 2020). In addition, contact tracing is also impacted by fear, discrimination and stigma (Mamobolo, April 2020).

Summary and conclusion of the health impact of Covid-19.

This chapter tells a deeply concerning story. C19 arrived in March carried by white privileged tourists between Europe and South Africa. Government acted early and drastically and won widespread praise for doing so. However, the lockdown and other measures left gaps through which the virus could spread and the pandemic catch hold.

Factors such as lockdown exemptions, state violence, institutionalised racism and sexism and inadequate food provision caused the pandemic to move from white privileged spaces into low-income, black residential areas. Here the pandemic connected to the existing disease burden, inadequate health facilities and poverty to cause devastation. At the time of writing we are confronted with the issue of “excess deaths” whose relation to the endemic must yet be clarified.

The pandemic’s disruptive effect on an already fragile health system was felt immediately. Of particular concern is that the arrival of C19 exposed the weaknesses in testing, contact tracing and quarantine facilities. The original lockdown was justified to give government the chance to prepare these. Not only does this mean that the lockdown has failed, but its impact will be felt even more as the C19 pandemic is by no means over.

3. C19 state policy measures

Managing the response to the C19 pandemic became important to the state to such an extent that it could be said to have become its main task. All arms and all levels of the state became involved. Numerous policy and other measures were taken and all of them had a strong impact on health equity. These measures also reflected the political priorities and orientation of the state, which has to be taken into account when activist work towards health equity is framed.

In this section we give an overview of the main interventions of the state and assess them in terms of their impact on health equity. We also raise points for reflection as to what this shows about the character of the state and what it could mean for Tekano and others working for health equity.

We discuss the measures and interventions of the state under the following categories:

- Infection control
- Health services
- Enforcement
- Economic stimulus
- Social welfare and protection.

Infection control

In the beginning stages of the state's C19 response, its main objective was to control, slow and prevent the spread of coronavirus. It enacted a number of measures that were meant to meet this objective. These included the:

- Declaration of a National State of Disaster on 15 March 2020 in terms of the Disaster Management Act of 2002[13], which included the establishment of the National Coronavirus Command Council as the centre for C19 government decision-making
- Declaration of a general lockdown on 29 March 2020, which included a stay-at-home order for all but essential workers
- Lockdown level 4 from 1 May 2020, which lifted some restrictions on travel and reopened certain parts of the economy
- Lockdown level 3 from 1 June, which entailed further easing of restrictions
- Mandatory personal protection measures such as wearing of masks, social distancing and hand hygiene
- Awareness raising and education about the virus and how to prevent infections
- Banning of trade in cigarettes and tobacco products on 27 March, which President Ramaphosa undertook to lift on 23 April, but has remained in place after cabinet seemed to overrule him
- Banning of trade in alcohol on 27 March, which was lifted on 1 June and reinstated on 12 July.

Key issues that arose around infection control

Although the initial measures announced by the government enjoyed widespread support, there were critical voices raising issues that were concerning from a health equity point of view. These included questions such as:

- Are the measures medically and scientifically valid?[14]
- Are they practicable? Can they be implemented?[15]
- Are they clear, consistent and understandable?[16]
- Are they legally valid?[17]

In time, these voices became more numerous and louder and commentators like Steven Friedman have pointed out that the high levels of public approval of government actions are no longer evident.[18] If the answer to any of these questions is no, it would mean the state has placed health equity in jeopardy. We now proceed to look at the impact of the state's infection control measures on health equity.

Impact on health equity of infection control measures

➢ The lockdown and the other infection control measures did not stop community transmissions. As discussed above, initially the infections were concentrated in wealthy areas because it was connected to overseas travel. But then the hotspots became black, low-income townships like Mitchell's Plain, Khayelitsha[19], Soweto.[20] Not only do these areas have higher numbers of infections, but people tend to be more severely affected by C19 than the wealthy who can afford special diets, supplements and private healthcare to support recovery and rehabilitation from the long term impact of the disease. The failure of the lockdown and other infection control measures to prevent the transmission of the virus in poor communities is bound to have serious negative effects on health equity.

➢ It may be argued that this was to be expected or unavoidable. From the beginning the government said the purpose of these measures was not to avoid the spread of infections, but merely to postpone the peak of infections in order to get the health system ready. This position was supported by the leading scientific spokespersons of the government.[21] This view is opposed by analysts like Steven Friedman[22] and Oupa Lehulere[23]. They have both written critical analyses that showed inconsistencies in the views of these leading scientists and pointed to examples of countries and interventions that managed to prevent the coronavirus from spreading in the way that it has in South Africa. These analysts located the failure of the government and the scientists in their contempt for the views, situation and interests of people in townships and informal settlements and in the commitment of government to neoliberal policies. Such a contempt, when it becomes the basis for policy, inevitably leads to decisions and practices that undermine health equity.

- Two questions arise: 1) Why did infection control fail? 2) Why are infections concentrated in poor, black communities? A number of factors form part of the answers to these questions. These include the fact that the goldmines and export wine farms were exempted from the lockdown, even when it was at its 'hardest' level. Conditions in these sectors make it difficult for workers to protect themselves, and migrant labour plays a big role in both, which aided the spread of the virus. A report on workers rights in the region had the following to say about mineworkers in South Africa:

  > *Mine owners say they have "plans" to operate safely at the pits. Work conditions in the pits, however, preclude social distancing. Workers go down into the pits packed in cages and work closely in teams at the face without visors or facemasks.[24]*

  This situation was made worse as more sectors of the economy reopened.
  A second set of factors had to do with the lack of access to food, cash and social protection that was made much worse by the lockdown. This forced people to break the lockdown rules and move around in order to seek food and other resources.[25]
  A third set of factors had to do with the lack of space and access to sanitizers, masks and other personal protective equipment. This made social distancing, isolation and personal infection control difficult to impossible. As one commentator puts it:

  > *the behaviours which are needed to stem COVID-19 are very difficult for most South Africans – those who live in the formerly blacks-only urban townships and in shack settlements. Overcrowding makes physical distancing very hard, clean water may not be available for hand washing and people are forced to travel in full minibus taxis.[22]*

  The fourth set of factors had to do with a breakdown of trust in the government, which comes out clearly from our interviews (Interview 3, 5, 7 & 8). The violence and intimidation of enforcement, media stories of politicians breaking lockdown rules and reports of C19 related corruption all had the result of people losing confidence in the state and not being receptive to even valid health advice. These and other factors explain how the pandemic came to disproportionately target poor, black communities, which was a blow for health equity.

Health services

All levels of the government[5] are involved in the delivery of healthcare and medical services and national government plays an important role in the regulation of private healthcare. An important part of the C19 response of the state was aimed at strengthening, repurposing and preparing the capacity of healthcare providers to deal with the pandemic. These measures included the following:

[5] National, provincial and municipal

- Scaling down the delivery of general health services to create space for anticipated C19 patients
- Ordering and stockpiling of extra equipment for treating C19 patients
- Screening, testing and tracking for possible infections
- Preparing quarantine facilities for the exposed and infected
- Preparing extra hospital beds, wards and sites for the isolation and treatment of C19 patients.

Key issues that arose around health services

Health services in South Africa are known to be unequal with the most striking divide between the private and public sectors.[26] The private sector is generally well resourced and capable of delivering comprehensive medical care that is claimed to be equal to services anywhere in the world, although it comes at the cost of excluding the vast majority of people through high pricing. The majority of people depend on the subsidised public sector, which is often under-resourced, stretched and in places overwhelmed.[27] Service delivery is further undermined by known corruption in the sector.[28] This pre-Covid situation posed questions with regard to the health services interventions of the state from the start, including the following:

- Did the health system have the will and capacity to carry out C19 related decisions?
- Was the scaling down of non-C19 health services not going to cause more health problems than it solved?
- Would minimum service standards be met? Would the public sector cope with the extra pressure? Would the private sector meet their obligation to make emergency care available to distressed patients who could not pay?
- Where would the money come from to pay for extra resources?
- Would procurement corruption and irregularities undermine service delivery?

Reports of corruption and irregular expenditure related to procurement of C19 equipment in the public sector are dominating the news cycle at the time of writing[29]. Of particular concern is that this was anticipated and that the president undertook to take measures to combat it when announcing the planned C19 procurement but seems unable or unwilling to effectively do so.[30] As worrying as corruption is, an exclusive focus on it by the media and the public may result in the underestimation of the factors raised by the other issues. If the underfunding of the public sector continues, if the balance in resource allocation between the 16% of the population using the private sector and the 84% who use the public sector is not corrected, if the resources that are concentrated in the private sector are not made available to those unable to pay, then corruption may be just one of the factors working against health equity.[31]

Given these challenges, what were the impacts of the state's C19 related interventions around health services on health equity?

Impact on health equity of health services measures

- Scaling down of general services affected users of public healthcare facilities as explained above in chapter 2. Special concerns were raised about people unable to access treatment for HIV/AIDS, but sufferers of chronic non-communicable diseases such as diabetes and hypertension were also affected. We could not find evidence that showed that a similar dynamic was at work in the private sector. We therefore conclude that it was primarily the users of the public sector system that was affected, which means inequalities were widened and health equity was undermined.

- The public sector took additional strain from underfunding and corruption[32], while the private sector continued to enforce its payment regime in the face of the epidemic and the state agreeing to pay up to R16,156 per day for state patients admitted to private hospitals.[33] This meant that health inequities that exist before the pandemic were not only maintained but strengthened.

- Mass testing was never fully implemented[34] and tracking of contacts was virtually abandoned because it took too long[6] for test results to become known.[12] Most of the testing was done in private laboratories as the public laboratories became overwhelmed. In March already a media report stated:

  > *Health Minister Zweli Mkhize said that of the 12,815 tests conducted as of 23 March, 10,000 were done by private labs and around 2,000 by the state laboratory services.[35]*

  This means it was mainly people who could pay who were getting tested. This further undermined health equity.

- Public quarantine facilities developed a reputation as places that were bad to stay in, especially after the death of the well-known entrepreneur Shonisani Lethole in a quarantine facility in July, after he had complained about being left without food and blanket on Twitter, tagging Health Minister Mkhize.[36] People chose not to go there. This meant it was mainly people who had the space to quarantine at home or who could pay for private access that ended up in quarantine. This is part of the reason why the virus spread so fast in poor communities. This undermined health equity.

- In the public sector, some of the expenditure on extra hospital beds and facilities went to waste because there were not enough staff and equipment to care for patients in the beds.[37] Expenditures that could have increased health equity actually decreased it.

Enforcement

[6] For tracking to be effective, test results need to be known between 12 and 24 hours according to Mendelson and Madhi

As part of its response to C19, the government promulgated regulations in terms of the Disaster Management Act. It then instituted measures for the enforcement of these regulations, including the following:

- Restrictions on certain human rights such as freedom of movement
- Increased powers or increased use of certain powers of police including powers of arrest and issuing fines for the new offences
- Mobilisation and deployment of the army to support the police
- Mobilisation of private security firms
- Curfews and travel restrictions
- Arrests, sentencing and fines.

Key issues that arose around enforcement

South Africa's first lockdown was described as among the severest in the world and some commentators said that this was to the credit of the government. A few raised concerns and critiques through, questioning whether the armed forces are the appropriate responders to a health emergency, especially given the already existing problems of police brutality against poor Black people.[38] There were also questions about the specifics of enforcement role that was expected of the armed forces, including the following:

- Were the measures taken to ensure enforcement constitutional?
- Were these measures practical, clear and consistent in a way that would facilitate enforcement?
- Were the existing records of systemic violence by these enforcement forces taken into account?
- What would happen to the enforcement of general rights and laws, e.g. around gender based violence?

Impact on health equity of enforcement measures

- ➢ Police brutality and state violence were concentrated in poor black communities.[39] People felt they had more to fear from the armed forces than from the virus. Eleven deaths and several injuries resulted from police and army actions in the first five weeks of lockdown.[40] The toll on physical and mental health increased health inequity.

- ➢ Gender based violence (GBV) was met with indifference by the police who felt their priority was to enforce the lockdown regulations (Interview 7). There was general confusion among politicians and government officials about GBV statistics and the availability of services to survivors. Police minister Bheki Cele reported there were 87000 calls for help with GBV to the police helpline in the first week of lockdown,[41] but that turned out to be the total number of complaints received in 2019.[42] The actual number for the first week of lockdown was 2300, which is concerningly high. Poor, black women were disproportionately affected and health equity was undermined.(Interview 7)

- ➢ There were inconsistencies in enforcement to the detriment of poor Black communities. An example is that while the ban on travel was strictly enforced, evictions of shack dwellers and tenants continued despite the moratorium on it.[43] Health equity was undermined.

- ➢ Fines were issued freely and had a bigger impact on poor people. Even homeless people were fined amounts of up to R1500.[44] Health equity was undermined.

- ➢ The armed forces interpreted the stay-at-home order as a stay-inside-your-home order, which in the beginning they enforced strictly and sometimes with deadly violence. In Vosloorus Gauteng, Sibusiso Amos was shot to death for being outside his home in his yard. Four of his nieces and nephews aged between 5 and 11 were wounded in the incident for which a metro police officer and a security guard were arrested.[45] For people staying in overcrowded conditions, being forced to be inside made distancing impossible, which facilitated the spread of the virus. Health equity was undermined.

- ➢ Oversight and recourse for victims of state violence were weak, as became especially clear in the case of Collins Khoza. With eleven people killed and more than 230000 arrested by June 2020, the president described it as 'overenthusiasm' on the part of the armed forces.[40] All the deceased were black men except one transgender black woman. The racist and classist pattern of the violence[46] coupled with the weak recourse clearly undermined health equity.

Economic stimulus

The lockdown closed down most of the economy and exposed many firms to bankruptcy or at least the necessity to adjust to the loss of income by cutting expenses. Firms responded by retrenching workers, cutting their hours or simply stopped paying their wages. It became clear that an economic depression was in the making with widespread job losses and company closures. Government took a number of measures to avoid and soften this, including the following:

- Initiation of the Solidarity Fund as a public benefit organisation through which to channel donations to C19 relief efforts
- Announcement of a Social Relief and Economic Support Package worth R500 billion (the stimulus package)
- Tax relief for businesses
- Changes to the medium term expenditure framework and the national budget intended to support businesses dealing with the consequences of C19 and the lockdown
- Early exemptions from the lockdown for some sectors such as wine exports and gold mining.

Key issues that arose around economic stimulus measures

South Africa has one of the most unequal economies in the world with glaring poles of degrading poverty and ostentatious wealth. Early in the pandemic a large group of economists and other scholars wrote an open letter to the government that located this situation in the legacy of Apartheid and the neoliberal policies pursued by the ANC government.[47] The letter called on the government to respond to C19 by breaking from this policy direction and adopting a more redistributive stance. A critic of the economists pointed out that the letter had little chance of success as the government had already indicated its intention to stick to the neoliberal policies that contribute greatly to inequality[48]. Later some of the economists criticised the government for not even fulfilling the promises of the social relief and economic support package.[49] This indicates concerns regarding the government's approach to economic stimulus as a whole, including the following:

- The conditions and impact of C19 related loans taken out from the International Monetary Fund (IMF) and the World Bank
- Would this mean austerity and cuts for social services, and support and subsidies for big business?

Economic policy is an important instrument for achieving health equity as health equity is centrally dependent on an equitable distribution of economic resources. Such a distribution assists equity in housing, food and other crucial resources for health equity. A major reason for South Africa's health inequities lies in the commitment to neoliberal economic policies by the government. Early indications that it would be more of the same raised serious possibility that these inequities would persist or even worsen.

Impact on health equity of economic stimulus measures

- ➢ Most of the economic stimulus package consisted of the tax breaks, subsidies and soft loans for businesses. It followed the trickle down theory of neoliberalism that states governments must support businesses and the benefits will trickle down to working class and poor communities. This has had the result of increasing inequalities and undermining health equity wherever it was implemented.

- ➢ The loans from the IMF and World Bank raises the possibility that this neoliberal framework will continue and be strengthened. These institutions are seen as the enablers and enforcers of global capital and have played a key role in ensuring the dominance of neoliberalism over the last forty years. Extending loans on condition that borrowing countries commit to more neoliberal austerity has been a key tactic for them. The loans threaten to further undermine health equity.

- ➢ The lockdown caused losses for the unemployed, workers, informal businesses and small and medium enterprises. On the other hand, the top sections of the capitalist class who own the mines, banks and supermarket chains benefited out of the lockdown, as they could continue to operate and their competition was closed down. The overall

dynamic was to increase health inequity by deepening the existing socio-economic divisions in South Africa.

Social welfare and protection

When it became apparent that the lockdown was causing widespread hunger and distress for the poor, government instituted a number of social welfare and protection measures. Most of these measures were temporary and designed to deal with the specific socio-economic consequences of C19 and not with the pre-existing hunger and poverty. The measures included the following:

- Feeding schemes and food distribution
- A new grant for the unemployed of R350/month for six months
- An increase of R500/month in the existing childcare grant and old age pension for six months
- The Temporary Employer/Employee Relief Scheme (TERS) for workers who lost wages and jobs
- Measures against exploitative price increases known as price gouging
- A moratorium on evictions.

Key issues that arose around social welfare and protection measures

South Africa's welfare and social protection policies have come to public attention on a number of occasions pre-Covid. There are regular reports on the positive impacts of the childcare grant and the old age pension, despite both of these being set below the poverty line. On the negative side there were problems with delivery and corruption scandals revealing the penetration of white monopoly capital in the grants delivery system and the consequent exploitation of grant recipients.[50] There could be little doubt that the expansion of social welfare and protection would have positive effects for the poor, but previous problems suggested possible concerns, including the following:

- Did the state have the capacity and will to carry out the stipulated measures?
- Could the intended beneficiaries actually access the resources the measures were meant to make available to them?
- Were these measures adequate in the sense that they actually relieved the distress they were directed at?
- Did the measures address stress, trauma and mental health?
- Was the role of civil society accounted for?
- Was self-organisation of poor communities taken into account?

An effective welfare and social protection package would be able to answer yes to all of the above questions.

Impact on health equity of social welfare and protection measures

- Media reports[51] and our respondents and informants indicated that people who need it most could not access these resources and services. The main reason seems to be high administrative requirements, which most people without internet access could not meet during lockdown. Filling in complicated forms and providing acceptable proof of registration were beyond the capacity of most of the people who needed the unemployment grant and TERS. (Tekano C19 Survey; interview 1, 3, 9 & 12)

- Feeding schemes and food distribution were also plagued by a number of problems. The three most important probably were that the need was greater than the supply, the government closed down established feeding schemes not run by itself while not replacing them, and allegations of corruption and favouritism were widespread especially where municipal councillors were involved. (interview 9)

- For those who managed to receive the cash, the amounts of respectively R350 and R500 per month were simply not enough to stave off hunger. This is especially significant in the face of evidence that anti-price gouging measures did not succeed in stopping price increases for basic foodstuffs.[52]

- The TERS payments faced bottlenecks that significantly undermined its reach and impact. The first was that in the beginning affected workers depended on their employers to apply on their behalf, who often refused to do so. The second was that the money was paid to employers who were expected to pass it on to workers, which often did not happen. The third was that workers who were not registered at the Unemployment Insurance Fund (UIF) at first could not apply, and when the government conceded that they could apply there was no procedure in place for them to do so. The fourth was that workers in the informal sector often lacked the proof of employment that was required.[53]

- The government acted in a manner that showed they saw the activities of civil society and the self-initiatives of poor communities as a problem rather than a positive. This caused conflicts, breakdowns and inappropriate deliveries. It is known that effective social welfare and protection programmes are usually based on taking the lead from civil society and community organisations. Police and army violence, widespread allegations of corruption and the continued illegal evictions by government institutions further undermined the trust between government on the one hand and civil society and community groups on the other. (interview 3)

- The overall effect of these problems was to constrain and undermine the potential positive impact on health equity of these social welfare and protection measures.

Summary and conclusion on state policy measures

The lockdown instituted in response to the C19 pandemic had severe economic and social consequences, especially for poor black people. It is doubly problematic that it evidently failed as an infection control intervention. Measures designed to strengthen and repurpose health services, to facilitate the enforcement of regulations and to provide economic stimulus, similarly failed from a health equity point of view. The inequities besetting South Africa and its health system and status could be said to have been made worse by these measures.

The most pertinent explanation for this situation is that the state remained true to the neoliberal policy model that it had been faithfully following since at least 1996, and that has produced and reproduced the striking pre-Covid inequities. This model has always included the state providing faithful service to the upper elite of white monopoly capitalists, in particular the owners of the financial, mining and agro-retail sectors. Another element of the neoliberal model was the use of the state as a source of wealth accumulation for the politically connected black middle class and capitalist groups. The final element was the state directing suspicion, contempt, mistrust, marginalisation, exploitation and violence to the Black poor in the townships and informal settlements. These elements of the neoliberal model were all present and even strengthened in the C19 policy measures of the state. It placed severe limitations on the impact of the social welfare and protection measures that were enacted.

The unavoidable conclusion is that a health equity agenda requires the inclusion of a political struggle against the neoliberal model and its proponents. This struggle is already visible in the conflicts between the state and the self-activity of the poor.

4. Socio-economic impacts

This chapter focuses on the impact of Covid-19 and the lockdown on the socio-economic conditions in different sections of South African society. Although C19 had officially 'arrived' in South Africa in March already, its impact was felt mostly after the implementation and enforcement of the lockdown. For poor and vulnerable communities who depend on movement to assemble livelihoods and make a living, the lockdown caused immediate hunger and suffering. The lockdown amplified existing crises around the absence of basic services like water and housing in black rural communities, informal settlements and townships as people living under those conditions have been unable to take measures to protect themselves from Covid-19. The C19 language is used to refer to existing crises. Gender based violence has been named the 'shadow pandemic' and hunger, inequality and poverty are also referred to as pandemics.

In this section we provide an overview of the ways basic needs and services were affected and what happened to labour and working conditions for workers in different sectors of the economy. We discuss the socio-economic impact of C19 and the lockdown and the implications for health equity under the following categories

- Food security
- Housing
- Water
- Electricity
- Labour

Food Security

According to Stats Sa (2019) South Africa is food secure at the national level, but insecure at the household level. In 2017, 20% of households did not have access to adequate food, 6,8 million people experienced hunger. Two thirds of these households reside in urban areas and they are almost exclusively black and coloured-headed households. Food insecurity is not caused by the availability of food, but by affordability and access. During the lockdown, food security issues that were highlighted were experiences of restricted or no access to food and increased hunger, food distribution systems and the disruption of informal food markets.

Key issues that arose around food security

In April and May there was an immediate steep increase in hunger experienced by adults and children. The NIDS-CRAM survey results (2020) showed that 47% of respondents ran out of money to buy food in April. A significant increase from 21% the previous year. 21% of the respondents indicated someone in their household had gone hungry in May. Hunger was the result of loss of income, closure of school feeding programmes, increased food prices and

restrictions on movement and unavailable public transport. This was not a surprise given the poverty and unemployment rates before lockdown. Hunger was predictable and inevitable. National and international media reported on protests and 'looting' erupting in big city townships like Alexandra and Mitchells Plain as a result of hunger and desperation. There were also protests around demands for food parcels and over promised food parcels that never arrived. Protesters expressed their concern clearly "we are not going to die of the coronavirus, but we are going to die of hunger".

A report by the Foundation for Human Rights (July 2020) found that 80% of their respondents, Community Advise Offices (CAOs) throughout the country, reported that people experienced difficulties with accessing food during lockdown. There were also problems with the availability and delivery of food parcels. 19% of the CAOs indicated that communities did not receive food parcels at all. Whereas in most provinces local government was the biggest distributor of food parcels, Gauteng and the Western Cape communities relied more on civil society for the delivery of food parcels.

Hunger in rural areas has received much less attention in the media. Informal food markets were disrupted and shut down during the lockdown. This blocked people from accessing food and small-scale producers from distributing food. Small-scale farmers stopped production because they could not buy seedlings and inputs in towns. One respondent (1) shared that in rural areas bakkie traders and people with vehicles were used by NGOs in getting food to households in need. This created opportunities for farmers to sell their produce, but sometimes they sold at cost price and made no profit. A question that emerged is the sustainability of such markets and food systems when they require NGO involvement and funding. Civil society and community members that wanted to provide support had to negotiate the permit system and at times NGO accounting mechanisms.

During the lockdown an increase in 'illegal hunting' and 'poaching' was reported by farmers and owners of livestock and wildlife in rural areas. Meanwhile, agribusinesses and large-scale farmers were enabled to produce, distribute and export food.

Impact on health equity of food security:

- Food insecurity and hunger have a negative effect on health. Hunger and food insecurity occurred in poor black communities and increased existing health inequity.
- Increased food insecurity and hunger has severe health and development consequences for children and reinforces existing inequalities and health inequity.
- Food prices increased which exacerbated the effects of loss of income and had a negative impact on health equity.
- informal and smallholder sectors were disrupted during the lockdown whereas large-scale agriculture continued doing business and generating income and profits. Loss of income and no access to food affected black rural communities who were more food insecure during the pandemic which intensifies health inequities.

Housing

At the beginning of the lockdown, the main measure imposed by the government to protect people from covid infections was for people to stay-at-home. Additional measures demanded from people to avoid spreading the disease were self-isolation and quarantine. The possibility and success of these protective measures rely on housing conditions. Existing realities for the majority of poor black communities is that people reside in dense formal and informal settlements or are homeless. The provisions made for these vulnerable populations were inadequate at best and harmful at worst. Even more astonishing has been the deliberate increase of homelessness through ongoing evictions during lockdown.

Key Issues that arose in housing:

Despite the moratorium on evictions during lockdown level 5, 4 and 3, they were carried out as usual by cities such as Cape Town, Johannesburg and Durban. The evictions are carried out by law enforcement and private security companies. Cities legitimise removing people from informal houses as a way to combat 'land invasions'. Civil society reports and the media documented evictions and the Human Rights Commission went to court and applied for an interdict of the anti-land invasion operations in Cape Town. There have been cases like women who have been arrested for violating the lockdown after they were evicted and sleeping in an open field.

Another major issue in housing is the struggle of tenants. There have been reports of tenants being evicted or being cut off water and electricity for not paying rent. There has been no relief for tenants who due to job losses and income cuts could no longer afford rent.

Homeless people were treated as criminals for being on the street during lockdown. Some resisted going to shelters where there was no food and where conditions and rules violated human rights like the infamous strandfontein camp. An initiative by an Observatory resident to shelter homeless people was met with law enforcement officers who claimed that they were 'contravening bylaws'. Although the government announced they would provide shelter for homeless people and women facing violence at home, this promise was not delivered. The administrative process to access shelters was confusing and obstructed access at times. There was confusion between testing and screening requirements which made the work of organizations supporting people in need of shelters more difficult. Women living in the streets of Johannesburg were not transported to shelters by SAPS when they requested (Interview 7). There was inadequate support to shelter vulnerable people and shelters like the Strandfontein Emergency Shelter placed people in inhumane conditions.

Impact on health equity of housing:

- ➢ The protection of private property and its owners directly undermined health equity during the lockdown as already vulnerable populations were made homeless, exposed to harsh winter conditions, and dispossessed of their dignity and safety.
- ➢ The conditions in some of the shelters made the risk of coronavirus infection worse and generated trauma and mental health issues.

Water

The issue of access to water and sanitation has received much attention because hand washing is a key protective measure against coronavirus infection. Access to water in townships and rural areas has been a key political power struggle in South Africa where water is in many instances a privatized commodity and many poor and black communities are excluded from access and use with detrimental consequences for health and health equity.

Water is closely related to black women's lives and concerns as they fetch water and use it for household and agricultural activities. The intimate relationship between women and water was reflected in the fact that the C19 Women's Solidarity Forum wrote a letter to the government, who set R20-billion aside for municipalities to provide emergency water supplies and other urgent needs, to address the water crisis urgently. The plight of women in mining and commercial farming areas was highlighted. Mining communities already carry heavy disease burdens and they were affected as the result of longstanding struggles about mining operations capturing water sources at the cost of surrounding communities' access to water and sanitation. The poor water and sanitation infrastructure on farms affected the conditions for farm workers and dwellers.

Issues that arose around water:

Many public institutions that the majority of people in South Africa rely on did not have access to water during the pandemic. This includes public clinics and schools. Communities tried to force service delivery by municipalities with mixed results. The Fighting for Water Justice coalition in Ceres (Western Cape) managed to temporarily stop the installment of water meters and water tankers were still needed in the informal settlements. In many places people did not receive water or the promised water tanks from the government.

Water access and supply was used as a weapon against vulnerable people. In urban areas landlords cut water of tenants who did not pay rent in order to evict tenants. Similar power abuses were reportedly used by white farmers who refused farm dwellers access to water. People like the women in Somkhele (KZN) who demonstrated for their right to water were arrested and detained.

Impact on health equity of water:

- ➢ No (secure) access to water and sanitation increases health risks. Communities without access to water and sanitation are more exposed and at risk which increases health inequities.
- ➢ The privatization of water, and natural resources in general, undermines a health equity agenda as in times of crisis power holders weaponize ownership and control of basic resources such as water.

Electricity

The government and Eskom committed to uninterrupted electricity for the duration of the lockdown. Water and electricity cuts are common tactics used by landlords to punish non-paying tenants. Tenants and shack dwellers have been particularly vulnerable.

Issues that arose around electricity

Despite promise of uninterrupted electricity, black people in townships experienced power cuts. Municipalities are not accountable as they did not respond to queries. Protesters were shot at by the police and traumatized by the presence of the army. The impact of electricity cuts for poor people is severe. Those who spend resources to stock up food for lockdown had to dispose of food that went off because fridges/freezers did not work. Electrical appliances were permanently damaged and people cannot afford to replace them. Lack of electricity disables access to information, internet connectivity, cell phone reception and communication. Tenants who were no longer able to afford to pay rent were cut off electricity. Landlords use this to make tenants leave/

Health equity impacts of electricity:

- ➢ The government failed in delivering basic services such as adequate housing, water and electricity. These services are generally essential for good health. Health inequities expanded.

Labour

In the context of existing high unemployment rates and low wages of the working poor, job losses and retrenchments as a result of the lockdown immediately deepened poverty and inequality. Concerns have also been raised in relation to working conditions for those workers who operated during the pandemic.

At the start of the lockdown, 3 million people lost their employment. Job losses were concentrated amongst already vulnerable groups in the labour market: women, black people, youth, less educated people and informal/casual workers (NIDS-CRAM 2020). 42% of men and almost 50% of women who were employed reported working fewer or no hours. It is unclear at

the moment how many of these jobs returned after the hard lockdown in both the formal and informal economy. The worst-case scenario of treasury is that seven million jobs will be lost.

We observed a significant difference between government regulations and guidelines for employers and workplaces and the realities of vulnerable workers including domestic workers, mine workers, farm workers and healthcare workers operating during the pandemic. High levels of non compliance with labour law by employers is common in South Africa's labour relations. Power differences were heightened as vulnerable workers had to negotiate their need for income with being exposed to risks and power abuses by employers who used the exceptional circumstances to justify actions such as lowering wages, locking workers in or out of workplaces, forcing workers to take their leave and/or reduce hours.

Issues that arose around labour

The reopening of more sectors of the economy under level 3 was presented as a necessary relief measure for poor people who need access to money to survive. Dominant beliefs that the economy needs to be 'saved' and that jobs are ways out of misery for black workers persisted during the pandemic. In reality however, the majority of the black labour force that 'returned' to work were exposed to the virus and during this period there was a steep increase in community transmissions.

Here we explore how C19 and the lockdown impacted on workers' access to labour rights, health and safety, wages, benefits, working conditions, and what this means for health equity. We try to understand the massive retrenchments and job losses during this period and also address the impact of Covid and the lockdown on communities where workers live as spheres of production and reproduction impact on each other and on health equity. At the moment of writing there are alarming numbers of infections reported in mining communities. We will zoom in on the experiences of mine workers, farm workers, domestic and healthcare workers.

There are general observations on the impact of Covid 19 and the lockdown on workers. During lockdown workers had no real access to labour rights institutions such as the department of labour and the ccma. Unions were not considered essential during the lockdown and sometimes struggled to access workplaces and workers. Workers faced occupational health and safety issues when PPE was not provided or when managers refused to close down workplaces after infections were detected. The black working class relies on public transport, especially taxis. When the economy reopened, black precarious workers were more at risk by using taxis that filled up 100%. Employers responded by reducing salaries and working hours. The National Bargaining Council for the clothing manufacturing industry announced that an agreement was made with stakeholders that the 80.000 textile workers would be guaranteed full pay during the 6-week lockdown. This seems exceptional. Many workers were retrenched. In June, non-food retailer Edcon (Edgards, Jet) served 22.000 employees with retrenchment notices. More than 1800 retrenchment cases potentially affecting more than 100.000 workers have been referred to

the CCMA during lockdown. These cases follow an existing wave of retrenchments by big corporates in the last two years.

Impacts on health equity of labour

- ➢ Exposure to Covid19 through use of crowded public transport and working conditions that were not adjusted to ensure social distancing, sanitizing and other protective measures to prevent infection.
- ➢ Widespread non-compliance of employers who disregard safety protocols for workers increased the risks for these workers.

Mining

There are 450.000 workers employed in the mining sector. Mining has been deemed an essential service and throughout lockdown mines were allowed to operate. In March there were already 2 positive Covid-19 cases. Deemed essential were coal mines supplying Eskom, gold and platinum production. An employee in the mining industry that wanted to remain anonymous questioned the 'essential' nature of continuing the export of high-grade coals in the New Frame. Some mining operations were legitimised by the department and the mineral council because they were "too costly" to shut down. It is clear that economic interests guided these decisions. Initially there was a scaling down of production which impacted workers. The New Frame article stated that most employers took the position of "no work, no pay". Contempt for mine workers was revealed when Mantashe said in his address about the lockdown that "it is not a paid holiday".

The state of infections on Friday 17 July:

- 5396 positive Covid-19 cases in the mining industry.
- Breakdown: platinum: 2853, gold: 1450, coal: 693, other mines: 2 infections.
- 45 deaths.
- Industry claims the testing rate is 63% higher than in the rest of the country.

On 5 August, Neil Overy wrote that the Minerals' Council of South Africa (Mincosa) is desperately denying that mines are the epicentres of infection. Government ministers in mining areas are stating mining areas are Covid hotspots. Figures indicate that those living near mines are more likely to become C19 positive than people who live elsewhere. Overy explains that the higher testing rate does not fully explain the more than double positive rate among miners, other factors are at play. According to Overy, Mincosa needs to deny the facts because pressure from grassroots organizations and NGOs impacts the legitimacy of mining.

Mining communities are witnessing increased numbers of infections and deaths. Mines are underreporting as they only measure illnesses and deaths of strictly employees. But the impacts of mining do not stop at the gate. Mines appropriate water at the cost of community access and burden people with diseases.

Issues that arose in mining areas:

There is a high risk of infection for miners due to mining conditions. Migrant mine workers in gold mines were not paid and could not travel home during lockdown. Mines retrenched workers during lockdown.

Activists in affected mining communities reported (communitymonitors.net) on conditions including shortage of medication in the clinics, no access to water, no access to food that made people initiate food gardens. Susan Moraba from the mining community monitoring school in Mpumalanga reported on 5 August on the SABC news that the number of sick people has increased in coal mining areas because many people who now emerge with breathing problems were already sick. There is a lack of statistics on mining-related illnesses in the communities. She felt that mining companies do not assist communities. There is not enough medicine and medical staff. Health inequities are worsened.

Health equity impacts of mining:

- Mining communities already have high incidences of chronic respiratory diseases: asthma, TB and lung illnesses. This makes people more vulnerable for corona. Combined with the lack of access to healthcare and resources to prevent and treat infections, health inequities are increased in mining communities.

Farm workers

Farming operations continued to ensure food production. There are about 650.000 farm workers and the majority are women (Devereaux, 2020). The commercial farming sector is known for its human rights violations. Different organizations called on the government to monitor safety regulations on farms during the pandemic.

The media reported on one Ceres farmer who was issued a notice by the Department of Employment and Labour for transporting workers from the Eastern Cape to the Western Cape and non-compliance with Covid regulations. The same region was identified as a hotspot in May as 209 Covid cases were recorded in the Witzenberg area and linked to the transporting of seasonal farm workers.

In The Sunday River Valley in the Eastern Cape, harvesting season started in April and there were great concerns for the risks farm workers would be exposed to. Farm workers rely on mobile health care services accessed only 4 times a year. Farmers faced labour shortages due to the restrictions on travel. In June, thousands of citrus farm workers went on strike because they were not paid the R20 minimum wage.

Issues that arose for farm workers:

- Influx seasonal migrant labourers during pandemic caused anxiety and risks for residents in rural townships and farms. Movement across provinces raised concerns about the spread of infections through returning seasonal farm workers.
- Women seasonal workers in the Western Cape were done with harvesting on the grape and wine farms by the end of March, just before lockdown. They could not access UIF funds as labour centres were closed during lockdown. This leads to food insecurity.
- Black farmers were harrassed when getting inputs at co-ops and ended up fighting with officials who assumed they were not performing essential services.
- Farmers used disciplinary procedures to control farm dwellers' movements and chased people of farms.

Health equity impacts farm workers:

➢ Working and living conditions of seasonal and migrant farm labour increased risks of infections. In remote areas, there is no access to healthcare services. This exposes this category of workers to greater health risks and reinforces health inequity.

Domestic workers

Domestic workers have been badly affected by the lockdown. They lost income, were sent on unpaid leave, unfairly dismissed and didn't receive employment benefits. There are about one million domestic workers and they are almost exclusively black women. The precarious employment circumstances make them vulnerable to experiences of abuse and unfair treatment. Domestic workers are often underpaid and even their minimum wage is only 15 rand an hour.

Issues that arose for domestic workers:

A survey conducted by Izwi amongst 600 domestic workers in the Johannesburg area in April showed that only 20% of domestic workers were registered for UIF. Women who stayed in employers' houses during lockdown reported they were not allowed to seek medical care or leave to be with their families or buy groceries. Many employers don't comply with labour regulations. For domestic workers, the lockdown immediately resulted in hunger and evictions. Izwi quoted domestic workers commenting on their situations in April:

> *"Unable to pay my rent, Buying food for me and my children. I am a single mum."*
> *"My boss didn't pay me she said she won't be able to pay me cz she don't have an income n I'm not sure if I will get back to work after this coronavirus".*

"I was stopped from coming to work because of corona virus until further notice. Was told to rent a place close to work so that I won't take public transport or else I look for another job".
"Since i am not working i don't have any other source of income to buy food".

Under level 4 lockdown, only live-in domestic workers and caregivers were allowed back to work. From 1 June, under lockdown level 3, all domestic workers were officially allowed to go back to work. Government decided at the end of May that domestic workers who work more than 24 hours per month and were not registered for UIF, could also claim TERS benefits. Representatives of the United Domestic Workers' of South Africa (UDWSA) reported in the media that they were concerned about the safety of domestic workers going back to work. They stated employers must provide PPE and inform domestic workers if someone in the household is feeling sick.

Black domestic labour is deeply entrenched in South Africa's social fabric. Wealthy and middle class people feel entitled to domestic services to such an extent that in many access-controlled residential estates domestic workers were 'allowed' in before family members or visitors. This illustrates how perceptions and decisions around essential services are intimately tied to the interests of those classes who exploit and benefit from cheap black labour.

Impact on health equity of domestic workers

- Domestic workers are predominantly black women workers, sometimes migrant workers. They serve the needs of the middle class for low pay, little benefits and having to negotiate everyday racism and personalized power dynamics in the homes where they work. During covid they were exposed to risks of infection whereas the people they worked for were better able to protect themselves. This exposed existing inequities.

Healthcare workers

Healthcare workers in the public and private sector have been at the frontline of the pandemic dealing with sick people and especially in the understaffed and under resourced public sector with inadequate resources to perform their work. There are big differences between the sectors, but also within public and private facilities. Increasingly, both the public and private sectors rely on the work of community healthcare workers, nurses, cleaners and security guards whose working conditions are precarious.

Private sector infections in June:

- Life Healthcare: 16,376 employees, 313 staff and doctors infected, 1.9%
- Netcare: 21,000 employees, 232 infected, 2 deaths.
- Public sector healthcare infections end of May: 2,084, 80% in Westen Cape. By the beginning of August, more than 24.000 workers were infected and 181 deaths. Infection rate stands at 5% of all cases.

An vulnerable section of frontline workers in the healthcare sector are community healthcare workers (CHWs). They are community members recruited through NGOs. There are about 65.000 community health workers and the majority are women. Their conditions of employment are difficult with low wages and high job insecurity and no support from health facilities where they work.The actual work is stressful and at times dangerous. The Department of Health announced that 28.000 CHWs would go house-to-house in vulnerable communities to screen and test people. For them PPE is critical as they get exposed and in their work might spread the virus as well.

Issues that arose for healthcare workers:

There was insufficient PPE for protection from infection. The report of fact-finding mission by NEHAWU raised many concerns about working conditions of healthcare workers as well as dysfunctional healthcare systems. Non-unionized workers in the sector such as community health workers in the Eastern Cape experienced violent responses from the police when they went to the Department of Health to demand permanent jobs.

Black Mediclinic workers were accused of catching covid by the use of taxis and going to malls. Managers denied that frontline workers were infected at work. Workers say the hospital does not want to close for an outbreak because they would lose money.

There were contradicting guidelines from the national and provincial government on testing of healthcare workers. Tekano Fellow Amy Green wrote that many healthcare workers could not work for certain periods because they were at home awaiting test results.

Impact on health equity of healthcare workers.

- ➢ Employment patterns that shift an outsourced and insecure workforce in the healthcare sector increases social and race inequity. Workers at the bottom of the labour hierarchy are predominantly black and women.
- ➢ The differences in working and employment conditions within the public and private sector increase health inequity.

Summary and conclusion on socio-economic impacts

The socio-economic impacts of the lockdown are deepening existing crises around hunger, access to basic services and employment. The immediate experience of hunger fuelled protests and paved a way for the government to claim that ‘re-opening’ the economy would be in workers’ best interest. No provisions were made for the known fact that South African employers regularly don’t comply with labour laws. The realities of the working poor illustrate that in many instances their safety has been compromised whilst going back to work. Low paid black workers

have to use public transport, have to struggle for PPE at work, face power abuses by managers and employers, have to negotiate the absence of childcare for children who were not going to school, which all increased stress and affect the general health and mental health of workers.

5. Civil society, engagement and leadership

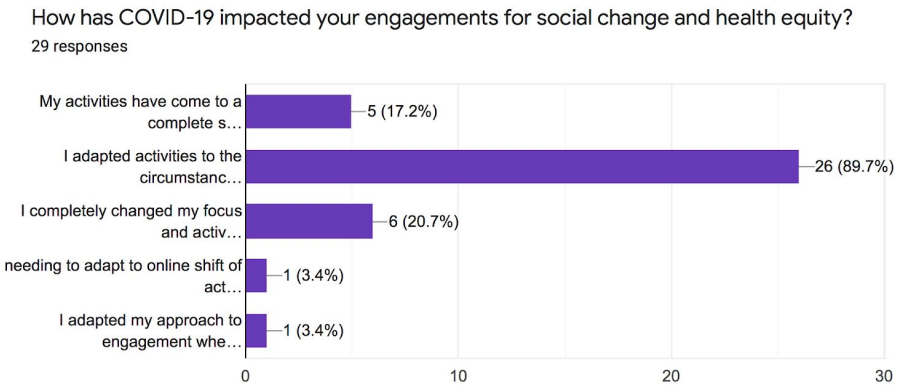
This chapter focuses on engagements around C19 responses within civil society and between civil society, the state and ordinary people. We focus on experiences within the Tekano network and their meanings for promoting health equity. Before lockdown, certain sections of civil society called upon a range of organizations to meet and prepare a civil society response to Covid-19. This resulted in platforms and alliances that are unique to the current circumstances and in this chapter we explore their strategies and impact on health equity. Another important finding of the research is presented here, namely the self-activities that emerged and responded directly to needs of vulnerable communities. Lastly, we focus on the issue of leadership. What forms of leadership emerged during the pandemic and how do we reflect on the meanings of different kinds of leadership for health equity?

We discuss the civil society, engagements and leadership under the following categories:

- Types of interventions
- Alliances and platforms
- Engaging the state
- Relating to business
- Relating with labour
- Funding and resources
- Self-activity of communities.

Types of interventions

The travel and gathering restrictions during the lockdown made it difficult for NGOs and other civil society organizations to continue working as usual. Programmes and activities scaled down, stopped or were adjusted. Civil society organizations invested in devices such as laptops and phones and internet connectivity for staff members so they could work from home and participate in meetings. Some invested in technology for their beneficiaries as well.
The survey [54] results reflect that almost everyone adapted their activities to the circumstances. For 5 respondents their usual activities came to a complete stop and 6 respondents indicated they completely changed the focus and activities in relation to engagements for social change and health equity.



The shift of activities was often a response to immediate needs of beneficiaries. These included distributing food parcels to households in need, providing information on C19, providing PPE and medical services and/or emotional support.

Issues that arose in types of interventions:

The scaling down and stopping of programmes was seen as a loss when the organization had to close, when staff lost salaries and income as a result and when organizations lost access to beneficiaries. In other words, respondents struggled to see closing down as a positive contribution to infection control. A key informant working in the gender based violence sector initially expected that during lockdown there would simply be no work (Interview 7). This view changed, as soon into the lockdown it was apparent that government did not provide support and services for their beneficiaries. In rural areas, it has been a challenge to connect to people in remote areas without network and reception. Connection and participation now relied on access to data and airtime which cut sections of the population off from support networks.

A key informant working at a rural NGO said: “As the organisation we were caught with our pants down” (Interview 17). Several staff members of NGOs felt that their organization was not adequately equipped to operate in the crisis. The shift to working from home exposed a lack of trust in relationships between managers and staff. Managers were seen as unprepared, inflexible and unnecessarily increasing workloads of staff members by insisting on receiving weekly reports. This was difficult for staff members with care responsibilities at home and bad internet connectivity.

Soon into the lockdown it became clear that GBV support was needed as usual reporting and support systems were inaccessible to women facing violence at home. Challenges in providing support included administrative procedures at shelters and non-cooperation from SAPS. Civil society organizations working with precarious workers reported that government institutions were not available to apply for Covid-19 relief. This caused immediate hunger and distress amongst women seasonal farm workers, domestic workers, and informal sector workers who were without income during the lockdown.

Advocacy groups SWEAT, Sisonke and the Triangle project published a joint statement about the discrimination in policing during lockdown. Black and poor people have been policed differently from white and middle class people. The statement was issued after the death of Elma Robyn Montsumi in police custody in April. Elma was a sex worker. Sex workers experienced an intensification in harassment by the police who harassed and targetted them for contravening the lockdown. Migrant sex workers felt they were also targetted because they are migrants. In general, women and men who live and work in public spaces faced police brutality.

The Women's Legal Centre, Section27 and the Sexual and Reproductive Justice Coalition wrote a letter to health minister Mkhize in April to demand safe access to sexual and reproductive health services during Covid-19. They raised concerns about restricted access to these services and the experiences of marginalised people seeking these essential medical services, including abortion. They demanded access and protections for LGBTQIA+ people, young women, sex workers and people with disabilities. In June they sent a follow-up letter.

Courts remained open during lockdown, but it was difficult to access them as moving in public spaces was heavily regulated and public transport was not available. These were serious obstacles for black women who needed courts to get protection orders against abusers. There were numerous in the country protests against gender based violence and femicide around the time of Tshegofatso Pule's murder. In two weeks, 21 women and children were murdered. The President mentioned in his speech on 17 June that the country was in the middle of two devastating epidemics.

The lockdown highlighted race and gender inequities as the living and working conditions of black women were most adversely impacted by the lockdown. The limited access to sexual and reproductive health services increased gender and health inequity.

Alliances and platforms

The well known example of a civil society alliance that emerged in the context of Covid19 is the C19 People's Coalition. Numerous survey respondents (24.1%) and key informants in the Tekano network participated in this platform. On 18 March the Tshisimani Centre for Activist Education in Cape Town convened the first meeting where people joined on a voluntary basis. On 23 March the Coalition published a call on all people and a programme of action [55] that was initially endorsed by over 200 organizations (more endorsements later). The programme of action addresses everyone in South Africa including government, employers, citizens, the middle class, and households and states that:

> Our response must be just, equitable, and redistributive if we are to meet the needs of all our people. In times of physical distancing, social solidarity is key.

From the primary research we learned that in this platform activists and NGO members that would usually not work together, did so or met for the first time. The connections were not always long lasting. Our research found that people left after a while because "there were meetings every day" and it was taking too much time/data (Interview 6) and "most C19 working groups have now collapsed as donors became involved and some people got paid and others not" (Interview 13). On their website, the C19 Coalition posts statements around issues like the demand for accountability for shootings of community health workers on 17 July 2020. On 2 August they reported on the national day of working class action. The statement said that:

> This was the most extensive protest since 1994, in the sense of its national reach and the combination of rural and urban, communities and workers, and many different organisations that have not previously collaborated.

Different working groups and subgroups were formed around topics of health, food, economics, labour, gender and many more. Groups worked on their own campaigns and interventions. The cash transfers subgroup (of economics working group) made a parliamentary submission and started the #paythegrants campaign.
More new connections through alliances were mentioned by interview respondents. In the Eastern Cape an informant's organization joined the water caucus. Another alliance that was formed was the Working Class C19 Campaign.

<u>Issues that arose around civil society alliances:</u>

Why was there a need for new alliances in the civil society sector? One informant explained that: *"*To us it was clear that working alone would not have impact. Rural communities would be suffering. Circumstances forced us to work with others to maximise impact" *(*Interview 3*).* However, this logic applies outside the C19 context as well, yet civil society is divided in different groups.

> *Civil society usually operates in their own silo's. They don't want to expand. The crisis forced people to expand. Of course there were tensions and problems, different ideologies and ideas, but strong connections were made* (Interview 6)*.*

What was the impact of the alliances? Were their demands met? What were the impacts of interventions? The broad C19 People's Coalitions published statements at different points of the lockdown. The working groups engaged in different interventions and activities carried out by members. Food working group members documented experiences of small farmers, mapped small food producers and identified their needs in order to respond meaningfully.

Informants who participated in the C19 food working group also engaged with the Minister of Agriculture, Land Reform and Rural Development, Angela Thoko Didiza, around the exclusion of small-scale farmers who could not benefit from government relief. The minister did respond and the eligibility criteria were adjusted to include small-scale farmers who earn less than R20.000 per year. Although some farmers have now been able to apply, we don't know if any of

those farmers have benefitted yet. A group called the Eastern Cape Water Caucus intervened when local leaders were arrested under lockdown for holding a gathering and managed to get the case withdrawn. They also experienced instances where they put pressure on local and provincial government departments with no response at all.

One survey respondent shared their experience of frustration with engaging in some of the platforms that existed in response to Covid-19:

> *I have been really frustrated to see people who have little lived experience of being black, poor and marginalised (and who have not directly worked with these communities) driving the agenda and being the main advisors to Government and the public, and dishing out de-contextualised advice. I have sat in many virtual meetings as the only or one of few POC where we were meant to discuss issues like hunger, food insecurity, reopening of schools etc, where the majority of the discussants speak from a detached, intellectual perspective and not from true knowledge or experience of living or working in the areas where these issues are prevalent.*

We think this is an important comment and probably a wider shared experience in platforms where participants are from different class/race/gender backgrounds and where middle class politics dominates.

Health equity impacts of alliances and platforms:

- ➢ Alliances of civil society organizations tend to be dominated by middle class people and civil society professionals. Would they be prepared to give up privileges in order to transform to a more equitable society? Without addressing questions about positionality and privilege it will be hard to generate a health equity agenda that will not perpetuate inequities.

Engaging the state

There were numerous attempts by civil society to engage the state as the consequences of the lockdown were unfolding. Letters, petitions, and comments were made on the state's policies and their implications. Civil society organizations engaged with municipalities and provincial departments. Taking the state to court seemed an effective strategy because the state chose to then come to a settlement with the party who threatened to take legal action. Examples of court actions against the state are:

- The Casual Workers Advice Office with support of Izwi Domestic Worker Alliance and the Women on Farms Project submitted a court application against the Department of Employment and Labour on the unfairness of the TERS scheme. The Department settled and made amendments to the TERS directives.[56]

- Mid-April mining trade union AMCU took the Department of Mineral Resources to court. The judge decided that the Department must impose instead of advise mandatory regulations for mining companies in their C19 response to miner's health.[57]

- Afriforum took the Department of Health to court over a Covid-19 quarantine camp. The court ordered that the camp should be closed immediately.[58]

- The SAHRC challenged the interdict from the City of Cape Town about refusing to allow monitors to check the conditions in the camp. There is a dispute about who should pay legal costs. The Strandfontein Emergency Shelter was closed on 21 May.

Scientists have publicly criticized and responded to the state with recommendations for change. A group of 100 economists and researchers wrote a letter to the standing committee on finance to recommend a rejection of the supplementary budget that plans to reduce state expenditure and undermines the promise of the R500 billion rescue package.

Issues that arose with engaging the state:

The state of disaster enabled the state to not engage civil society. A key informant who operates in the health advocacy space and who participated in the C19 People's Coalition said: "we constantly tried to reach out to the government, but they retreated behind regulations. Public participation was really only by invitation….big business had a bigger say than civil society" (Interview 13). This view was confirmed in the survey responses: only 1 of the 29 respondents in the survey indicated that the government responded meaningfully to civil society. 13 respondents said that the government ignored civil society altogether.

The national state has not been very responsive to civil society engagements that did not force engagements through court action. Engagements with municipal government had more varied outcomes depending in some cases on established relations and understandings in the area. An interview respondent (Interview 1) involved in food distribution shared that two government officials helped them in their own capacity as their office did not have funds for them to support the initiative. Another respondent who works for an NGO was convinced he never managed to get a permit, like his colleagues, because of his bad relationship with local authorities. The dominant experiences of civil society engagement with the state during the pandemic consisted of civil society facing law enforcement, engaging in permit procedures, and experiencing non-responses.

What does this mean for health equity

➢ It is necessary to go to court to force the state to engage with civil society and advocates of health equity. Litigation is expensive, time consuming and often requires legal experts.

Relating to business

The Solidarity Fund has been an 'independent initiative,' registered as a public benefit company. It states on the website that it is acting as a platform for the general public, civil society and the public and private sector to respond to the Covid-19 crisis. The fund was designed as a rapid response vehicle to support government and non-government organizations in prevention, detection, medical and humanitarian support. Millions of rands have been donated by wealthy business families such as the Ruperts, Oppenheimers and Motsepes, banks, and mining companies. Donations to the Solidarity Fund are tax deductible. Two publications on the Solidarity Fund's website report donations going as grants to the National Department of Health and businesses to deliver PPE to the public health sector and food parcels to households in need.

The Oppenheimer and Rupert donations are administered by their own representatives. The Oppenheimers established the South African Future Trust in partnership with the major banks to provide interest-free loans to financially sustainable medium, small and micro enterprises. The Rupert family donated 1 billion rands that is administered by finance company Business Partners Limited which is co-owned by Johan Rupert. This money is also meant for helping small and medium enterprises.

Issues that arose in business engagements:

Civil society actors generally do not expect big business to contribute to the goals of civil society, or to even care about people. One key informant formulated this as "business has never been at the forefront of humanitarian and development work. They will not be after COVID. They will use COVID as an excuse for not creating jobs and developing people. The same will happen with NGOs. The smaller NGOs will step in to help communities" (Interview 9). Large NGOs are perceived as businesses in this informant's perception.

It is telling that a new term emerged in relation to business opportunities created by the pandemic: 'COVIDpreneurs', referring to people/companies benefiting from COVID-related tenders and procurements.

Health equity impacts of business engagements:

- Service provision by the private sector, in collaboration with the state, gives power and control to the private sector. Civil society, labour and local communities are sidelined in deciding how and where resources are used and whose interests and needs are met.

Relating with labour

We observed very few engagements of civil society with trade unions. There were some relations of support with non-unionized workers. This suggests the goals of the trade unions in

terms of social equity are not the same as those of civil society. This is not surprising given the fact that the majority of workers are not members of trade unions. They are precarious workers who earn low wages, have no job security and are excluded from collective bargaining and accessing worker rights.

Issues that arose in relation to labour engagements:

The tension between the interests of unions and of social society in promoting health equity were illustrated during the protests of community healthcare workers at the Department of Health head office in Bhisho, Eastern Cape. The group of elderly black women demanded permanent employment as some of them have been working on three-months contracts since 1992. The police attacked them with stun grenades and pushed the women with shields. The South African Federation of Trade Unions (SAFTU) came out with a statement of support for the community healthcare workers and sent a memorandum to the department. The Eastern Cape working group of the C19 People's Coalition also published a statement demanding dignified employment for community healthcare workers. A COSATU aligned mainstream trade union like NEHAWU is not defending the interests or supporting the demands of community health workers (Hlatshwayo 2018) although their members benefit from the services these frontline workers deliver in communities (Tekano community health workers webinar 2020).

On 1 August there was a nationwide day of working class action that brought together communities and non-unionized workers in protests against the government's Covid-19 response.[59] Trade unions were not part of this civil society alliance. The problems with reopening the schools were addressed by both civil society formations like theC19 Education Crisis Committee and SADTU (South African Democratic Teachers Union) although they seem to focus on different demands around protection of teachers and children from infections and possible educational disadvantages caused by the lockdown.

Health equity impacts of relations to labour:

- ➢ In the healthcare sector relations between civil society and unions are ambiguous because healthcare workers and professionals in the public sector do not necessarily use the services themselves. Are their interests aligned with health service users in the facilities where they work? Do civil society groups have the same goals as the unions representing the interests of healthcare workers?

Funding and resources

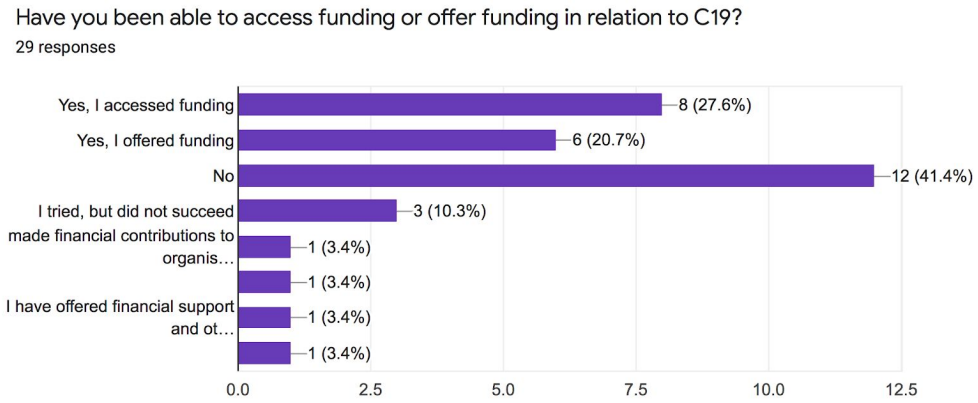
The primary research has generated insights on the impact C19 and the lockdown had on funding dynamics in South African civil society. On the African continent as a whole, a study on the impact of C19 on CSOs on the African continent (June 2020) found that:

- 71.94% of CSOs was self-funding their activities related to Covid.

- Local individual donors (41.84%) and the private sector (25.85%) were found to be the most significant contributors to those who secured funding. Government was one of the least significant contributors.
- 71.85% of CSOs felt that governments failed to recognize and utilize CSOs.

It is striking that both government and (international) donor/funding organizations were not the main providers of funds for Covid 19 related activities initiated by CSOs. At this point it is important to emphasize the difference between funding and money. Funding is conditional money that needs to be accounted for in specific ways, is received through specific administrative processes and spent through predetermined budget categories. Money can be used immediately to respond to needs during emergencies. Money is important because during emergencies there are many unforeseen expenditures and there is no time for administrative processes.

Issues that arose around funding and resources:



Two key informants referred to Tekano Covid 19 Emergency Support they accessed during this time. It enabled responding to immediate needs of beneficiaries in organizations that redirected their activities. This included providing access to food and water.
Existing funders and donors made Covid19 emergency grants available. But especially in big donor organizations systems of accounting and administering funds/donations were not adapted adequately to emergency circumstances. It would still take time to engage in due diligence processes and funds to be transferred into bank accounts, there would still be conditional aspects to how the money must be spent or accounted for. Several key informants (Interview 1 and 7) explained that they were unable to get receipts from people they worked with during the emergency, such as bakkie traders and ordinary people helping out with distribution of goods. This created more work for recipients of funds who were already working very hard to mitigate disaster in their community responses.

Complex administrative procedures around funding in big donor/funding organizations likely exclude grassroots formations and unregistered community groups who are not registered or have bank accounts for their group. Yet, these were the people who needed money fast. This is echoed in the observations of research participants who were unsuccessful in accessing funding. One survey respondent remarked that: “I actually witnessed the suffocation of CSO's and smaller NPOs who wanted to provide help. There is a monopoly within the NGO sector, which is creating extreme inequity within the sector”.

We encountered one example where (Interview 7) goods in kind were donated by Gift of the Givers to an organization that did not have the transport and storage capacity to receive the number of goods they were gifted. They had to pay people from their own pocket to receive and distribute these items to people who needed them. These dynamics caused them to decline certain funding offers because they recognized they would not be able to comply with the conditions attached to it.

The impact on health equity of funding:

- Funding cycles and relationships are highly bureaucratic and focus on systems of control. In an emergency situation like now, these systems are not effective in responding to immediate needs. In some instances funders’ offerings were declined or irrelevant because it would generate more work for recipients of funds. Access to money for people mitigating negative health impacts is important.

Self-activity of communities

Our research findings highlight the importance of self-activity in response to the human suffering caused by the lockdown. Both our primary and secondary research data shows that ordinary community members played a crucial role in providing immediate relief for the needs of vulnerable people in their surroundings. These responses were fuelled by compassion and an ethics of care that was mobilized swiftly and effectively in many places. They focused on food, but also PPE, water and emotional support where needed.

A well known example are the Community Action Networks, CANs, that were formed in big cities like Cape Town and Johannesburg. It is access to food, water and safe ways to self-isolate that drive activities of CANs, according to reflections of some of their members. In Cape Town over 170 CANs exist now in the city that together form a network called ‘Cape Town Together’. The CANs operate through neighbour level solidarity and the network is largely led by women.[60]

The responses from individuals in the Tekano network confirmed that provision of food and PPE were amongst the key responses to C19 and the lockdown. More than half of the survey respondents (55%) indicated they provided food to hungry people. Many observed and recognized grassroots initiatives and voluntarism as examples of leadership during this time.

From our interviews with key informants we heard that they witnessed that “community people just did what needed to be done…ordinary people really stepped up. Heart warming to see that on the one hand, but on the other hand sad that that is what we have to do” (Interview 7). Self-initiative is understood in relation to lacking government support as the expectation is that government cares and provides for people. An interview respondent based in a rural area expressed the need for a focus on self-reliance of rural people through state support for access to land and resources that enable food production (Interview 3). Women were key in coordinating local responses to identify and reach out to households in need (Interview 12).

Issues that arose in self-activities of communities

Self-organization of people in communities that have inadequate access to resources and services is not new. The fact that everywhere communities responded quickly to local needs suggests that there are existing networks of volunteers and community structures that were used to respond to the emergency. Churches, savings groups, and sports clubs are all well known locally-based support networks that exist everywhere. Were the relief efforts of communities based on these existing social formations? Women were observed to play key roles in coordinating relief efforts and ensuring that households in need were reached.

We found that there was severe state repression of self-activity during the lockdown. The lockdown rules and permit-system made it very difficult for ordinary people to initiate activities that provided relief and support for vulnerable people in need. People distributing food parcels were arrested or fined or stopped and accused of violating the lockdown. People’s efforts to provide shelter for homeless people were labelled unlawful and dismantled. Community leaders planning to address water shortages in their rural area were arrested for ‘gathering’. Instead of supporting existing networks of mutual aid and support of poor and black people, the state crushed them with heavy policing and military surveillance.

Impact on health equity of self-activity of communities:

- During the pandemic the state severely repressed self-initiatives of people organizing relief efforts in their communities. This directly undermined the role of the state to protect all people during the disaster. Is the state an appropriate institution to achieve health equity in South Africa when it constantly attacks people caring for homeless and vulnerable people?

Summary and conclusions civil society, engagement and leadership

The pandemic has dramatically shifted civil society activities, relations and funding needs. It generated enormous levels of self-activity that responded to the needs of vulnerable people in poor and black communities in both urban and rural areas. The engagements of ordinary people were directed at immediate needs and driven by an ethics of care and solidarity. These efforts stand in stark contrast with the often ineffective engagements with government and big

organizations that are stifled by bureaucracy and protecting vested interests and power. Our research notes with concern the repressive responses of the government to protestors, civil society members and ordinary citizens who speak up, act and contest inequities in South Africa.

A key observation that emerged during the research is the difference between people in perceived leadership positions and leadership shown by ordinary people. Media discourse as well as interview and survey respondents showed disappointment and anger towards people in leadership positions such as political leaders, municipal councilors or managers in civil society organizations. Concerns around corruption and capacity dominated the perceptions and experiences with government leaders. These 'failures' in leadership are often presented as explanations for the severe impacts of C19 and the lockdown on vulnerable populations. We view these 'failures' as results of structural and systemic inequities part of South Africa's neoliberal government framework.

The primary research data revealed many respondents witnessed and recognized responses of ordinary people, especially women, and grassroots organizations as crucial in mitigating the crises of hunger and other immediate problems as a result of the lockdown. These people included ordinary community members, church leaders, local business owners, youth, and existing and new local organizations such as community policing forums, CBOs, and CANs.

A relevant question for Tekano would be to interrogate where they want to develop and support leadership for health equity in South Africa: in government and civil society or in spaces of self-organization?

Chapter 6: Social equity and social cohesion

Throughout this report we have illustrated how the COVID-19 pandemic and the lockdown has impacted vulnerable and marginalised groups of South Africans. We have shown how throughout this period of time, existing inequalities and the social problems that accompany them, were exacerbated. The restrictive lockdown regulations and limited governmental support, increased the levels of precarity that characterise the everyday lives of the majority of South Africans who live in impoverishment. COVID-19 and the lockdown, therefore, represents a direct threat to health equity. It has deepened health inequities in our society by putting disadvantaged groups at further disadvantage with respect to health and diminishing their opportunities to be healthy.[61]

In this chapter we discuss three key issues that lie at the heart of health equity: achieving social equity through the pursuit of gender and race equity and promoting social cohesion. We draw on the insights and responses of the key informant interview and survey participants in this chapter.

Gender equity

Mirroring other societal burdens, women bear a disproportionate burden in terms of the impact of and responsibility for dealing with COVID-19. Women are at the frontlines of the pandemic providing essential work, they experience the impact of reduced income and job losses and they are impacted by the increased incidence of GBV during COVID-19.

Economic impact of COVID-19 on women

According to Mackett[62] women are impacted by their participation in both formal and informal reproductive labour. This means that during COVID-19 and the lockdown women are participating in essential work in the healthcare, service and domestic environment, and then returning home to perform unpaid essential work in the home. This unpaid reproductive labour has increased during the lockdown meaning that women bear an even greater than usual burden of childcare and domestic tasks. One of the key informant participants reported that during COVID-19 the burdens of care of the sick and elderly, sourcing food and basic services, childcare and taking on homeschooling, as well as growing crops in food insecure environments, all fall on women.

However, the impact of this sphere on women during COVID-19 is also felt through job insecurity and loss of income. In terms of formal reproductive labour, the jobs that women perform tend to be lower paid and less secure[62]. Women face a ‘double disadvantage’, i.e., they experience a disproportionate share of job losses and they are employed in a category of work where there are higher rates of job losses (Casale & Posel, 2020).

In terms of job losses, Rogan and Skinner report[63] that two thirds of the 3 million people who lost their jobs during the lockdown are women. This figure becomes more troubling when we consider that, in February, women accounted for less than half of the workforce (47%) [64]. In the informal sector, e.g., domestic work, a lack of safety net meant that 31% of women were locked out of informal work and where they were able to continue working, they faced large cuts in hours. Women's earnings from informal self-employment were 70% lower in April compared to February 2020. In addition, 26% of women were locked out of formal work. The result is a drastic increase in extreme poverty, hunger and food insecurity.

A key informant in an NGO who focuses on securing women's livelihoods reported her frustration with the impact of COVID-19 on women's employment:

> *It's disgusting and sad to see how women are losing their jobs during COVID. The stats show this. We have come far as women in terms of our liberation; yet we are still dealt the worst blows; we are still struggling and being treated as if we are not good enough. (translated from Afrikaans)* (Interview 9).

Gender-based violence during COVID-19

Like many of the other vectors of risk that we have discussed in this report, GBV is a long and enduring social problem confronting South African society. GBV receives ongoing attention in the South African context through the consistent stream of incidences of femicide, rape and other forms of violence perpetrated against women. Almost daily, our news reports carry statistics about gender-based violence and according to the WHO, South Africa has one of the highest rates of violence inflicted on women and girls in the world. Data from police reports show that 1 in 4 women in the general population experience GBV. During the COVID-19 lockdown, GBV has been labelled the second epidemic, equally as serious as COVID-19.

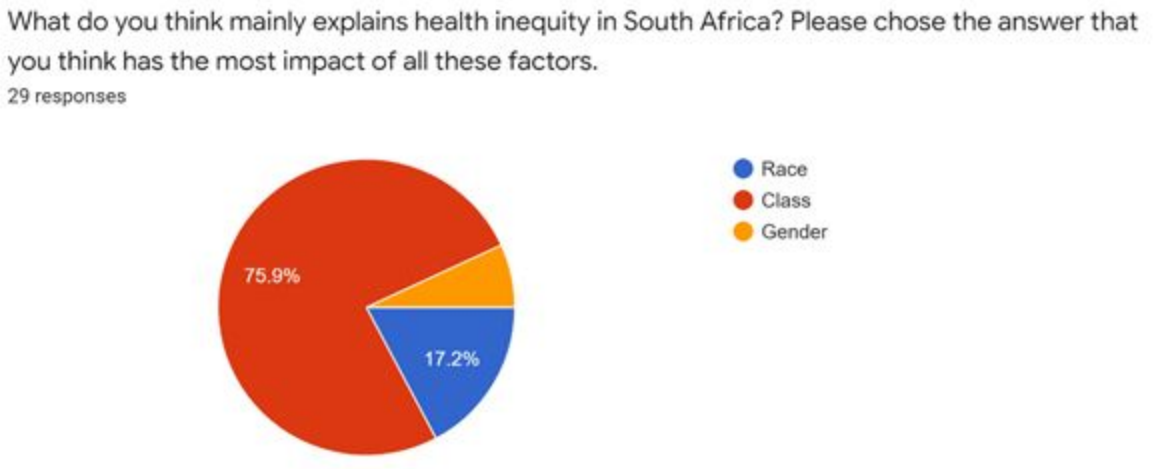
Reporting on GBV during the COVID-19 lockdown, the Foundation for Human Rights (2020) highlights the fact that an increase in incidents of GBV during the lockdown was widely reported. They conducted a survey[65] through community advice offices (CAO), 54% of whom reported an increase in GBV cases during lockdown across all provinces. They caution, however, that the situation is likely worse as GBV during this period may be underreported due to restrictions on movement. In terms of services available, three quarters of CAOs reported that they were able to offer support services to GBV survivors in their communities, with access to shelters being reported as very limited. In this regard, 88% of CAOs reported that they did not have any available shelters for GBV survivors in their communities. This means that GBV survivors are forced to remain in lockdown with their abusers.

In one of the first research projects exploring GBV during the COVID-19 lockdown, Nduna (July, 2020) highlights that high levels of domestic alcohol use during the level 5 lockdown, can be linked to GBV during this period. In what she refers to as a natural experiment, i.e., that the removal of alcohol, should decrease the rate of gender-based violence and domestic violence, she argues that the misuse of alcohol became more acute during the COVID-19 crisis. The

lockdown did not ban the consumption of alcohol in homes. In addition, while the purchase of alcohol was prohibited, the illicit purchase and production of alcohol continued. Over the period of the lockdown, the national command centre experienced an increase in calls from women who due to the proximity and visibility of the police turned to them for help at a time when they were restricted from accessing all other support resources, e.g. community-based services and personal social support networks. She argues that with the closure of schools, churches, workplaces and recreational activities, the continuum of GBV that is spread across institutions was transferred to the domestic sphere. The lockdown, therefore, domesticated polyviolence against women by confining perpetrators of GBV to their home and locking their victims down with them.

Race equity

In the sources that we consulted, the key informant interviews and survey responses, the issue of race as an existing social determinant that shapes inequality and that impacts health equity during COVID-19 and the lockdown received scant attention. In this regard, one of our key informants who mentioned race did so to explain how being of the same racial group as the beneficiaries of her organization, promoted the development of trusting relationships. As shown in the pie-chart below, in the survey only 5 out of the 29 participants who responded indicated a belief that race is a factor that mainly explains health inequity in South Africa. Twenty-two participants attributed it to class and two participants attributed it to gender.



This response to the impact of race on health equity is perplexing as we cannot ignore the fact that the people who are the beneficiaries of the organisations who we interacted with are black men, women and children. In spite of this silence around race, the factors that shape access to the resources that promote health and well-being and that form the foundation of the work that our key informants and survey participants are engaged in, are intimately interwoven with and determined by race in the South African context.

The relationship between racism, inequality and COVID-19 has received some attention in the international arena over the last few months. This is particularly due to the murder of George Floyd at the hands of a police officer in Minnesota in the USA. The response to his death has reverberated across the globe. In this context, it is the concern that BLM protests may trigger infection rates that has been foregrounded with respect to COVID-19. In the US and the UK, it has, however, again brought into focus the structural inequalities and intersecting systems of oppression that contribute to elevated mortality risk from COVID-19 in minority groups.[66] [67] Crenshaw points out that, in times of disaster like COVID-19, blackness is a pre-existing condition that exacts a disproportionate toll from those who are structurally marginalized and oppressed.[68]

Social and health phenomena in South Africa are always, already raced. This is no different with COVID-19 and its impact on the South African population. The endless stream of news and media reports that shape the narrative of the lived realities of COVID-19 present images and stories that highlight stark differences in the realities of South Africans. In this narrative harsh and damning judgements and assumptions are made about black South Africans locked down in poverty. Limited attention is given to the structural inequalities that have birthed these realities. In the Western Cape, on the second day of the lockdown, drone footage surfaced that showed that the suburbs in which privileged citizens were locked down, had been muted. In contrast, media images show that in settlements along the N2, where the black population went into lockdown, it was business as usual. In these overcrowded, materially deprived settlements, adhering to the stay at home order is not possible. People living in townships waiting in crowded lines to do their shopping are labelled irresponsible, disobedient and complicit in their own impending demise by news reporters who chastise them for not adhering to social distancing and the stay at home order.[69]

Black citizens also bear an elevated risk of becoming infected with COVID-19. As the working poor, they continue to move out of their settlements to perform low-wage, essential service jobs each day. They travel in mini-bus taxis and other forms of public transport to serve the privileged, bearing the burden of bringing COVID-19 back to their families and neighbours. Police brutality is also heightened during the lockdown. The police and SANDF patrol the streets and surveil the movements of people living in poor communities, harshly enforcing lockdown regulations that were not designed with these communities in mind. Images of police shooting rubber bullets at people living on the streets when they try to leave the cramped and poorly resourced tented camp in Strandfontein in the Western Cape, evictions and the demolition of homes in Khayelitsha, the daily humiliations, shaming, torture and beatings of citizens in townships all over the country, are all transmitted through the news media. In contrast, the privileged are portrayed as obedient, generous and selfless citizens who donate their money to COVID-relief funds and engage in charity to respond to the needs of poor South Africans during the lockdown. Against the backdrop of these stark presentations of South Africans under lockdown, we cannot ignore the fact that race inequities exist. We cannot contest the fact that COVID-19 and the lockdown has exacted its most severe toll on black South Africans who live in impoverishment.

Abdool-Karim [21] (April, 2020) points out that access to healthcare is the key determinant in the differential prognosis between the COVID-19 outcomes of rich and poor citizens. Access to healthcare in South Africa is raced. Yet, race, which is highly visible in the South Africa landscape, remains the invisible health indicator. Direct and explicit discussion about race and structural racism as a driving force of health inequities remain silent. This leaves us with the task of considering how we may unsilence it. Our historical legacy is one of successive systems of oppression that deliberately manufactured inequality by race. Race shapes every aspect of the lived experiences of South Africans of different race groups. We cannot, therefore, ignore its impact. We must fully explore its impact on health inequity in the South African context, before, during and after the COVID-19 pandemic. Race equity is an issue that we will explore in greater depth as we move forward with this context analysis.

Social cohesion

> "If we work together, if we keep to the path we know we have to take, we will beat this disease." (Ramaphosa, March, 2020)

The prevailing government narrative around COVID-19 has been one of solidarity, shared risk, shared burden, shared responsibility and fighting against a common enemy. However, the endemic inequalities that shape South African society, do not permit this solidarity to be shared by South Africans whose lived realities and trajectories diverge dramatically. In short, South Africans are not practiced in working together to pursue the well-being of the collective. These differences in lived realities are a direct threat to social cohesion.

When coronavirus first arrived in South African from Italy, privileged South Africans, in spite of appeals to desist, began stockpiling resources in anticipation of impending doom. Basic goods such as toilet paper, hand wash and cleaning products, as well as over the counter medications and supplements disappeared from shelves. These items became scarce commodities as those who could afford to do so prepared to protect themselves and their families against COVID-19. For some, part of this preparation extended to training their staff. In late March, video footage emerged of a white woman teaching black staff at a housing complex in Johannesburg how to wash their hands[70]. This incident that highlighted persistent infantilism of black staff and preconceived assumptions about black people as ignorant and unsanitary, provoked great outrage from the broader public.

The responses of black and white South Africans during the lockdown have also provided evidence of contradicting realities and priorities. These contradicting realities and priorities illuminate the unequal burdens carried by the South Africans who live privileged lives and those who live in poverty. While the primary occupation of South Africans living in impoverishment was a struggle to meet their basic needs for food, access to water and shelter; privileged South Africans were engaging in an entirely different set of concerns. For this group, challenging government to permit them to return to surfing; and outrage about the removal of roast chickens

from Woolworths stores throughout South Africa became their primary occupations. As Roper[71] phrased it: “A government ban on the sale of cooked chickens has awakened revolutionary fervour in South Africans – especially those who shop at Woolworths”. The damning divide between the lived realities of privileged and poor South Africans, and the actions and perspectives of the privileged, create an abyss in understanding what is required to address inequity. This is distressing given the fact that it is this group of South Africans who wield power in terms of resources and how they are allocated. A survey participant reported frustration with the lack of understanding of the realities of poor South Africans:

> *I have been really frustrated to see people who have little lived experience of being black, poor and marginalised (and who have not directly worked with these communities) driving the agenda and being the main advisors to Government and the public, and dishing out de-contextualised advice. I have sat in many virtual meetings as the only or one of few POC where we were meant to discuss issues like hunger, food insecurity, re-opening of schools etc, where the majority of the discussants speak from a detached, intellectual perspective and not from true knowledge or experience of living or working in the areas where these issues are prevalent.*

The perspectives of our key informants, who have been on the frontline of responding to the needs of poor South Africans during COVID-19 and the lockdown, provide some relief in the knowledge that, at grassroots level, solidarity and high levels of social cohesion prevail. On the 30th of March 2020 in an address to the nation on the ongoing lockdown and efforts to deal with the spread of the coronavirus, President Cyril Ramaphosa repeated his call for solidarity by calling on all South Africans to stand together to confront the national health emergency represented by COVID-19. On the ground in local communities, the impact of the COVID-19 lockdown was acutely felt. News reports highlighted the harsh realities faced by communities during this time. While the government feverishly planned and strategized around the public health strategy to stem the tide of infection; planning around aid and relief to alleviate the health, economic and social burden of the lockdown on vulnerable and marginalized groups lagged behind. At community level, it became clear that this government assistance would be long in coming and inadequate to deal with the acute levels of distress that communities had been forced into by the lockdown.

In this regard, according to the key informants who participated in this research, government response was lacking. In their view, the government's response to COVID-19 was created in a silo, not through engagement with community networks to assess their needs and the challenges that they may experience during the lockdown. The impact of this oversight was a lack of preparedness to deal with the panic, anxieties and fears about access to resources to meet basic survival needs and to implement COVID-19 safety guidelines. In the absence of government support and action on the ground, CSOs, NGOs, community organisations who are at the frontline stepped in to take action to respond to the needs of communities.

What transpired at the frontline of the impact of COVID-19 on communities is a rapid, emergency response to addressing the needs of communities locked down. NGOs, CSOs, community organisations and groups, activists and individual citizens, being confronted with the acute need of communities, banded together to develop a framework for collaboration, partnership, collective action, solidarity and mutual aid. The foundation of this framework is a relational network that supports engagement and collaboration between different role players and stakeholders, working together for the common good, and in pursuit of mutual benefit. Thus a high level of self-organisation occurred as people pooled resources to address the most acutely felt needs: food insecurity, access to water and other services, actions against evictions, ensuring access to ARVs and healthcare for people living with HIV, exploring ways for beneficiaries to continue generating an income under lockdown restrictions, to name a few. As one participant put it, the priorities were centred around: *"*accessing food, basic needs, basic resources and needs that reinforce the life and livelihood of the population*"* (Interview 14).

Building connections

> *To us it was clear that working alone would not have impact. Rural communities would be suffering. Circumstances forced us to work with others to maximise impact. (Interview 3)*
>
> *We like to work in silos, and we do not achieve much, thanks to the lockdown that we managed to do so much in so little. Yes, there are still problems but at least we have seen the importance of collaborations over a particular issue. (Interview 10)*

As the above quotes highlight, key informants reported that they realized early on that, given the challenges of the environment and the acute levels of distress and need, collaborating and building partnerships to secure resources and support for their beneficiaries was crucial. In this context agility and flexibility was required in order to remain attuned and responsive to the needs of beneficiaries. In terms of social cohesion, therefore, organisations worked to move beyond silos, collaborating, building partnerships, strengthening existing networks and expanding into new networks to access resources and support for their beneficiaries. Through these networks, organizations and groups shared information and were able to assist each other with finding new ways to access and distribute resources. For example, one key informant described how they worked with local farmers who are isolated and lack networks to create shorter food chains. Another key informant provided an example of collaboration and collective action to address enduring, pre-COVID challenges that a community experienced with accessing water. In this community NGOs, CBOs and activists engaged the government to secure access to water in communal areas without water.

Other functions served by the relational networks include information sharing, assistance with applying for relief funding, brainstorming, collective problem-solving and sharing experiences

and ideas. In this context, one key informant described NGOs as showing innovation with its own funding by filtering and reallocating resources to where the need is most acute.

In terms of leadership through these relational networks, the prevailing opinion amongst key informants is that the government did not take leadership for the well-being of its citizens. Instead citizens took leadership to support their own people and their well-being. In addition to what is considered formal leadership through organisations such as NGOs, CSOs, community groups and funders, natural, informal forms of leadership also emerged during the national disaster. In this context, the informal leaders who emerged at the coalface of communities included women and self-organised, decentralized groups like CANs. New people and new leaders emerged to provide situational leadership in response to the impact of COVID-19 on communities. As one key informant put it:

> *Community people, ordinary people just did what needed to be done. People would feed hungry people in their street. Grassroots really stepped up, particularly around the issue of food… Ordinary citizens really stepped up. Heart warming to see that on the one hand, but on the other hand sad that that is what we have to do. (Interview 7)*

Amongst the key informants, there is an atmosphere of positivity around social cohesion and the way in which organisations, groups and individuals came together and volunteered to step into the space of the needs of communities. Some of the benefits of the collaborations and networks created that are mentioned include expanding existing networks, connecting with organisations that they did not know existed and planning and meeting with new people and new organisations. One key informant described the solidarity and connections below:

> *I think solidarity was amazing, I thought the government would give more support to the NGOs, but that didn't happen. Instead different organizations worked more together. Zoom platforms that were created made a bigger impact, as we could share our stories. I was exposed to more organizations that I didn't work with before. That's been the opportunity and I think we will continue to work together beyond this COVID-19 crisis. We have become stronger* (Interview 12).

Collaborations and partnerships, however, were reportedly not without challenges. The lockdown resulted in a change in the forums in which people interact and the forms of relationships that form the foundation of interactions. With the restrictions on movement, people had to work out how to work together to meet the needs of their beneficiaries. This was facilitated by a move to virtual platforms, such as Zoom and whatsapp. However, use of these forms inevitably exclude those who do not have access to online platforms.

Summary and conclusion of social equity and cohesion

In relation to social equity and social cohesion our research echoes the fact that COVID-19 and the lockdown had a devastating effect on vulnerable and marginalised groups of South Africans. These groups may be identified by race, gender and socio-economic status; and more

accurately by the intersection of these social determinants. The vectors of risk and the axes of oppression are intersectional. It is these social determinants that have shaped the lived experience of COVID-19 and the lockdown as we have shown throughout the report. The observations of our key informant and survey participants that the government operated in a silo during this time is a damning indictment. Government's rigid focus on its public health management approach and lack of attention to the desperation and hunger of vulnerable and marginalised communities has left organisations operating on the frontline scrambling to respond to felt needs at community level. NGOs, CSOs and community groups have emerged as the leaders in terms of addressing health inequities during this time. Through their collaborations they have shown that, in times of disaster, it is possible to create flexible, agile and powerful relational networks and sources of support. The emphasis at government level must be to prioritise and expand its levels of engagement with the organisations operating at the coalface of inequality. It must work in close partnership with these organisations to tailor its relief and support efforts to the lived realities and challenges that characterise health inequality, in the time of COVID-19 and beyond.

7. Strategic considerations for health equity

Based on the findings of our research, we recommend the following strategic issues for consideration from a broad health equity perspective:

- What is the starting situation?
- What is the vision and the goal?
- How is progress measured?
- Role of public sector
- Role of private sector
- Politics and health equity
- The nature of activism
- The social bases of health equity.

All of these issues are of great importance, in our view, in crafting both immediate and longer term responses to the impacts of the C19 pandemic and lockdown. At the same time, none of them applies to C19 only. It would be better to think of them as relevant issues for health equity in general, which our research shows were surfaced by the pandemic. Each of them could be addressed from a perspective that responds to the specific impacts of C19 while seeking to take forward the general health equity agenda.

What is the starting situation?

Our research shows a situation of extreme inequalities and health inequities, made worse by the impact of the pandemic and the lockdown. Many people went hungry, were made homeless and struggled to meet their basic needs. The patterns of the spread of the virus reflected the race, class and gender divides of the country, which have remained modeled on colonialism and Apartheid. Access to health services were largely determined by the same social hierarchies.

None of this should come as a surprise as it is in line with public perceptions, media reports and research studies. The question for reflection is whether effective health equity activism would be served by a more concrete grasp of the state of health equity. ‘Everybody knows’ that health equity is in a bad state, but how precise is our knowledge and how common is our understanding? This raises the issue of the indicators of health equity, to which we return later.

For now we focus on the question: what is the state of health equity today? The public may have an idea that it is bad, but are they able to answer it with any level of precision? The same question applies to the Tekano network and other health equity activists. Is there a shared understanding of the state of health equity that was tested and reflected on in some way? If there is an announcement that, for example, 5 billion dollars is to be spent on promoting health equity, would the Tekano network and the public be able to venture an opinion on its likely

impact on health equity. Is such shared knowledge and understanding important for those working for health equity?

What is the vision and goal?

Our research indicates widespread disappointment with the attitudes and interventions of the state and its officials. This feeling was based on the assumption of at least some shared goals. A vision of health equity comprising goals described by the Bill of Rights of the South African constitution and the Alma Ata Declaration on Primary Healthcare is arguably justified in assuming common goals with the government. All institutions of the state are after all bound by the Bill of Rights and the government is officially in favour of prioritising primary healthcare. The declaration of a State of Disaster did not change that.

The fact that health equity proponents were nevertheless disappointed raises the questions whether the government deviated from its constitutionally prescribed commitments and whether these documents are concrete enough in their visions of health equity to show up differences in orientation. It is ultimately for the constitutional court to decide on the constitutionality of government decisions. Various particular regulations and actions were indeed challenged successfully, but at the moment there is, to our knowledge, no prospect of constitutional litigation based on the claim that the government has violated all the rights relevant to health equity.

In the meantime, for health equity proponents, there is the second question: is there a need to be more concrete and detailed in a description of a comprehensive vision of health equity? Perhaps the Sustainable Development Goals could offer a starting point and assistance for such a concretisation. Such a process of concretising vision and goals may raise the question of whether the achievement of health equity requires changes that go beyond the Bill of Rights. At the very least it would encourage health equity activists to show whether and how the Bill of Rights contradicts the neoliberal policy direction of the government that has undermined health equity and frustrated its proponents.

How is progress measured?

Many of our research respondents and informants have tools and systems to measure the outcomes and impacts of their work. For some this may be imposed from outside their organisations by funders who insist on monitoring and evaluation practices that enable them to track the impact of their funding spend. Despite this, most health equity proponents can see the advantages and even necessity of having agreed methods for the collective and shareable measuring of their progress towards their goals.

Since health equity proponents tend to work on one or more aspects of health equity, it means that they have in place a range of methods for measuring the progress of their work on tense

particular aspects. This raises the issue of the usefulness of such measures for health equity as a whole, rather than just for aspects of it that are of interest to particular groups and individuals.

In other words, what are the indicators that health equity is being achieved? And are such indicators important? This research has answered the second question in the affirmative, and intends to contribute to the development of answers to the first. It is, however, necessary for us to emphasise that the development and use of health equity indicators is a collective endeavour to be carried out by the community of health equity proponents as a whole. We, therefore, also propose collective reflection on health equity indicators.

Role of the public sector

It is generally accepted that the public health sector has a crucial role to play in the achievement of health equity. At the same time our research has shown and confirmed serious problems with access, service delivery and democratic ethos in the public sector. This is not the same everywhere, and perhaps the inequities *inside* the public sector do not receive the same level of attention as the contrast between the public and private sectors. There is nevertheless an important difference between the levels of service at a public health facility in a city suburb and one located in the rural areas of the former homelands.

This means that a simple expansion of the public sector is unlikely to deliver a health equity agenda. Health equity activists are called upon to reflect on the nature of the changes demanded inside the public sector by a health equity framework. We know, for example, that an important portion of the work done in public sector facilities and services are done by low paid, precariously employed, outsourced and labour brokered community health workers, cleaners, security guards and even nurses. How should this and other neoliberal practices in the public sector change in order to promote health equity?

Role of the private sector

The same kind of reflection is needed around the private healthcare sector. It is generally known that the private sector absorbs the bulk of healthcare resources and charges prices that only a minority can afford, most of them through medical aids. Major reforms to medical aids and the private sector have been seemingly promised over a number of years by the proposed National Health Insurance (NHI). Our research suggests, however, that interest in and knowledge of the NHI are relatively low among health equity activists.

This is a reflection of the need of health equity proponents to reflect more deeply about the nature of the private sector, its relations to the glaring problems in the public sectors, and the changes it would have to undergo in order to support a health equity agenda optimally. The inequities *inside* the private sector should also not be ignored. Do black women users of its services receive equitable care? What about the low-paid workers at the bottom of the system? Our research also suggests that many health equity proponents are users of private sector

health services and do not use the public sector. Some reflection on the meaning and possible impacts of this is perhaps called for.

The nature of health equity activism

Our research indicates that health equity proponents are involved in a wide range of activism and work. These include service delivery, training, lobbying, litigation, advocacy and movement building. Each of these different forms of activism are based on different assumptions and call for different types of solidarity and support, although most activists do a combination of them.

Delivering services, for example, is aimed at filling implementation gaps and not policy change. Litigation, on the other hand, may aim at better services and policy change, while its underpinning assumption is that legislation supports the improvement and changes it strives for. Lobbying assumes goodwill, the capacity to change and an open ear on the part of authorities, whereas advocacy relies on public pressure to deliver change. A movement building approach assumes the problems run deep and the solutions require fundamental changes that will be resisted, hence the need to build a movement to fight for the desired objective.

Reflection is called for on the specific forms of activism that health equity proponents are engaged in. What are its underlying assumptions about the nature of the problems and the solutions? What kinds of support does it require? Does it need to be supplemented with other forms of activism?

Politics and health equity

Health equity is highly political because specific political actors will inevitably take a position for or against its agenda. The changes this agenda support involve power shifts across the whole political system.

This raises a series of questions regarding politics and health equity. What are the changes required in and through the political system? Where do particular parties, politicians, policies and decision making bodies stand with regard to health equity? Is it perhaps time to think about a health equity score to be awarded to particular political actors and the system as a whole? Necessary and fruitful reflection along these lines is possible.

The social base of health equity

Politics does not happen in a vacuum but expresses the interests of specific social groups. South Africa is arguably socially defined by its division into clearly discernible groups based on race, gender, class and other factors. It could be argued that white capitalists form one such social group with a racial, class and also gender identity and a vested interest in opposing health equity, because it benefits from the penetration of privatisation in the public sector and from the high prices and financialisation of the private sector.

What about healthcare professionals who work in the public sector but use the private sector? How likely are they to support a health equity agenda? And what can health equity activists do to ensure that they do?

To repeat, these considerations are not specifically geared to the impacts of C19 and the lockdown. It is about health equity in general. But C19 has foregrounded the need for them and given them great urgency. This illustrates the fact that building health equity also builds social resilience to C19 and to any similar pandemics that may come. C19 has hit the vulnerabilities created by the inequities of health statuses and systems in South Africa.

8. Lessons for immediate results

The C19 pandemic is still unfolding and it is unclear for how long the world may still be in its grip. There are indications that the number of new infections in South Africa may be dropping, but the problems with testing may have something to do with that. In Europe and Asia, in the places that were the early centres of the pandemic, there are fears of a second wave of new infections.

We, therefore, thought it important to reflect on the lessons we could draw from the research that could have an immediate impact if implemented. The strategic considerations discussed above, could produce action plans for immediate implementation, but many of them would have effects that would be felt in the medium to long term. The points we draw from our research and reflection in this section are those ones we believe could have an immediate positive impact if implemented. The following list is not complete but offers a starting point:

Food

Food provision and sharing has been shown to be one of the greatest needs among the affected. Most solidarity activity has as a consequence concentrated on this, although the need is still great. Any extra resources and people dedicated to this task will have an immediate impact. It not only addresses hunger, but it also makes it possible for people to stay home and avoid spreading infections. Most food provision projects have taken a charitable delivery model, but there is space for more radical approaches. Places where supermarkets are hoarding food can be identified and targeted for pressure to share. Price gougers of food can be exposed and targeted.

Tracing

Contact tracing is one of the weakest elements of South Africa's C19 response, which is particularly unfortunate as it has proved to be crucial to successful responses to the pandemic. This needs to be addressed. A combination of pressure on government and self-organised contact tracing by communities is probably the best way to go. At the moment we are not aware of any community practicing self-organised contact tracing, but it should be possible to do and it is bound to have an immediate impact, including putting a focus on the need for adequate quarantine facilities.

Litigation

Our research shows that during the pandemic government only engages civil society and poor communities after litigation has been instituted. In most cases settlements are reached before the conclusion of the court case. But the process of engagement that makes the settlement possible does not happen without a court case. If poor communities need to engage the

government about anything, support with instituting litigation can have the immediate result of making this engagement possible.

Self-activity

Our research reveals the importance of self-organisation and activity in poor communities. Even litigation and engagement is not enough to ensure access to rights and resources without self-organised activity. This activity happens through the initiative of individuals who mobilise pre-existing relationships and networks and it is seldom connected to officially established organisations. Providing support to these individuals, networks and activities in a form preferred by them and accessible to them is almost guaranteed to have an immediate impact. Often the support needed is manageable resources such as simply being present, small amounts of cash, airtime and help with completing forms.

Money

Our research shows the importance of making the distinction between money and funding. Many individuals and groups who are on the frontlines of the C19 response would say that they need financial support to make their work more effective. This may be interpreted as a request for funding, but there is a danger in that. Funding is money accessed through a predetermined application process, on stipulated conditions for agreed purposes. There is also an agreed accounting process. Funding requires investments of time and skills that groups sometimes lack or are not prepared to commit to that purpose. Groups sometimes need money without the conditions that accompany funding. Providing funding in such a situation can create more problems than it solves. Making money available, even in relatively small amounts, that can support self-activity without the conditions of funding, is bound to have an immediate impact.

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