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## “... It is like it has come up and stole our lives from us” The first 21 days: A rapid qualitative assessment of how different sectors of society experienced the COVID-19 lockdown in South Africa

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### ABSTRACT

We examined how different sectors of society experienced the first 21 days of the stay-at-home lockdown following the onset of the coronavirus disease 2019 (COVID-19) pandemic in South Africa. This rapid qualitative assessment was conducted remotely with 60 key and community informants from different socio-cultural and economic backgrounds in Gauteng, KwaZulu-Natal and the Western Cape provinces of South Africa. Atlas.ti.8 was used to facilitate qualitative data analysis. Data revealed how the lockdown exacerbated social inequalities for the poor and marginalised. Fear of infection, and food and income insecurity were common concerns mentioned in key and community informant interviews. Despite the social and economic distress, the data also point to a narrative of social responsibility, resilience and social cohesion. The social responsibility and cohesion demonstrated by South African communities should be drawn upon to invoke community resilience, even in the absence of physical proximity.

### 1. Introduction

In December 2019, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the strain of coronavirus that causes coronavirus disease 2019 (COVID-19) was identified in Wuhan, China (Di Gennaro et al., 2020; Epidemiology Working Group, 2020; Huang et al., 2020; Perlman, 2020; Shereen et al., 2020). SARS-CoV-2 has an extremely high infection and relatively high mortality rate (Ahorsu et al., 2020).

The first case of SARS-CoV-2 in South Africa was reported on 5 March 2020 (National Department of Health, 2020a). Most cases at that time were people returning from overseas travel, mainly from countries in Europe. On 15 March 2020, the South African government declared a national state of disaster (Government Gazette. Disas, 2020). By 18 April 2020, South Africa reported 3034 confirmed SARS-CoV-2 cases. Thirty days later, confirmed SARS-CoV-2 cases increased to 15 515 (National Department of Health, 2020b). The highly infectious nature of the disease led to an intense epidemiologic and public health response.

To prevent community spread of the disease, the government announced stringent restrictions based on a 21-day stay-at-home national lockdown starting from 26 March 2020 (The Presidency of South A, 2020). Subsequently, many of these restrictions were extended or relaxed, depending on outbreak peaks and troughs. During the 21-day stay-at-home national lockdown period, only workers employed in sectors that were designated as essential services were allowed to leave their homes (The Presidency of South A, 2020). Essential workers included healthcare providers and support staff; the police; and those in the food and retail industry (The Presidency of South A, 2020). Those who required medical care or needed to shop for essentials were allowed to leave their homes for restricted periods or under strictly controlled conditions (National Department of Health, 2020a; The Presidency of South A, 2020; National Department of Health, 2020). In addition, the government deployed the South African National Defence Force to support the South African Police Services in managing the lockdown. These approaches helped to contain COVID-19 and improve the responsiveness of overstretched health systems (Harries et al., 2020;

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Logie & Turan, 2020). However, in South Africa as elsewhere, an anticipated increase in infections followed the first confirmed cases of SARS-CoV-2. At the one year mark, South Africa had recorded 1 513 393 confirmed cases of COVID-19, 49 993 deaths and 70 527 vaccines administered (08 March 2021) (National Department of Health, 2021).

Other countries implemented similar measures such as travel bans, lockdowns and movement restrictions to contain the spread of the disease (Donnarumma & Pezzulo, 2020; Iacobucci, 2020; Lewnard & Lo, 2020; Pepe et al., 2020; Qiu et al., 2020; Science News Staff. The U, 2020). This disruption to daily life meant that trade and commerce activities that were not deemed essential services were abruptly brought to a halt (The Presidency of South A, 2020). While such restrictions were considered necessary, it is important to understand how they affected the lives of people from different sectors of South African society. This is particularly crucial in a country with wide socio-economic inequalities, where the majority of the population lives in conditions unfavourable to social distancing, isolation or quarantine orders. Many people could not afford to stay at home and forego their only means to earn a livelihood (Botes & Thaldar, 2020).

The presence and spread of SARS-CoV-2 in South Africa exposed the country's long-existing economic, social, education, and health complexities and inequalities (Knutsson, 2020). Of the country's population of 59 million, only 16% are either members of medical schemes or can afford to pay for private and better-resourced healthcare, while the rest rely on the strained, under-resourced public healthcare system (Horn et al., 2020; Maphumulo & Bhengu, 2019; Naidoo, 2012). Despite social assistance programmes, poverty and unemployment continue to increase (Statistics South Africa, 2017). Moreover, even though social assistance programmes are widespread in South Africa, the monetary value is not enough to cover the most basic needs. The economic and social-spatial legacy of *apartheid* is visible in the geographic division of the country, with 13% of the population living in informal settlements, characterised by overcrowded conditions, widespread unemployment, a lack of clean water and inadequate sanitation (Selebalo & Webster, 2017; Todes & Turok, 2018). Most rural areas are impoverished. At the end of the month, many people travel to crowded cities to receive social grant payments and to purchase necessities (Seekings, 2011). Furthermore, South Africa carries a significant burden of HIV and TB. As the number of SARS-CoV-2 cases increased, the implication of COVID-19 for those living with these conditions became a concern (Mash, 2020).

Within this socio-historical context, we asked how the lockdown affected South African communities and how they responded to these COVID-19 containment measures. In this paper, we provide a rapid qualitative assessment of how different sectors of South African society experienced the first 21 days of the COVID-19 lockdown.

We purposively recruited different sectors of South African society to explore how the COVID-19 pandemic affected vulnerable and marginalised groups. This decision, which required a particularly sensitive approach towards the inclusion of these groups, was also informed by public health narratives that were dominant when the national lockdown was announced. For instance, the civil society sector raised concerns that, with the implementation of the national lockdown, no provision was made to provide shelter and access to healthcare services for homeless people (Cocks & Roelf, 2020; Kiewit, 2020a, 2020b; South Africa, 2020; Stent & Nowicki, 2020). Relief aid workers providing services to refugees, migrant workers and other undocumented people reported that these groups were neglected in the South African government's response to and management of the COVID-19 pandemic (Ncumisa, 2020; Scalabrini Centre of Cape Town, 2020; Zanker & Moyo, 2020). The situation of migrants changed during the lockdown, after the Scalabrini Centre (an NGO working for the integration of migrants, undocumented people and refugees in South Africa) brought a case against the Minister of Social Development in the Gauteng North High Court in Pretoria. The case centred on the exclusion of asylum seekers and other migrants from access to the R350 per month COVID-19 Social Relief of Distress (SRD)

grant (Cloete et al., 2020; Scalabrini Centre of Cape Town, 2020). On 18 June 2020, the High Court ruled in favour of the Scalabrini Centre, which means that asylum seekers and special permit holders from Angola, Lesotho and Zimbabwe, as well as asylum seekers with permits or visas that were valid on 15 March 2020, can access the SRD grant based on the criteria set by the South African Social Security Agency (Cloete et al., 2020).

Within this social context, it is important to note that the World Health Organization (WHO) has reiterated the importance for public health and social measures to slow or stop the spread of SARS-CoV-2 to be "implemented with the full engagement of all members of society" (World Health Organization WHO, 2019, pp. 1–19).

Other vulnerable groups may include sex workers, people living with HIV, people with disabilities, and people who struggle to access healthcare support. Moreover, research shows that a majority of the COVID-19 cases that result in mortality have underlying comorbidities (Richardson et al., 2020). Older people (aged 70 years and older) and persons (any age group) who have serious underlying health conditions (e.g. hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer) might be at higher risk for severe illness from COVID-19 (Lingeswaran et al., 2020; Lithander et al., 2020; World Health Organization, 2020). People from overcrowded townships and informal settlements may already be vulnerable as their living conditions and environments place them at greater risk of infection (Bulled & Singer, 2020).

For vulnerable communities, structural barriers often impede access to essential services such as healthcare (Logie & Turan, 2020). With the outbreak of COVID-19, resources have largely been diverted towards fighting the pandemic. For people with disabilities, there is an expectation that access to basic services including access to healthcare services and information during the COVID-19 outbreak will not be hindered (World Health Organization (WHO), 2020). However, at the same time, achieving this in practical terms proved difficult as some people with disabilities rely on others for their day-to-day needs and care (The Office of the United, 2020).

Exploring how different sectors of South African society responded to the pandemic will guide further monitoring of adherence to preventive measures as stipulated by the WHO. Moreover, drawing attention to how marginalised and vulnerable populations were affected by the pandemic is important to inform policy and mitigate further discrimination towards these groups. Insights into how marginalised and vulnerable groups experienced the 21-day stay-at-home lockdown could potentially be used to advocate for an inclusive approach to curbing the spread of COVID-19 or responding to future pandemics.

## 2. Materials and methods

### 2.1. Study design

Purposive sampling was used to identify and select participants to take part in the study. To ensure diversity, we purposively selected key and community informants representing various sectors of South African society.

Data collection was conducted in the Western Cape, Gauteng and KwaZulu-Natal provinces because these provinces had the highest burden of COVID-19 at the time of the rapid assessment. Using our existing network of contacts and with the support of civil society organisations (CSOs) and NGOs working with vulnerable groups, we identified key and community informants across the three provinces. CSOs and NGOs included service providers and social support networks providing services to vulnerable and hard-to-reach groups, such as people living with HIV, migrant communities and sexual- and gender-minority groups.

### 2.2. Study participants and setting

Key informants, according to McKenna and Main (2013), occupy

social and professional roles in communities. As expert knowledge holders, they help researchers to obtain quick and relevant data, which is crucial during rapid assessments (Payne & Payne, 2004, pp. 135–138). In our study, purposive sampling of key and community informants informed a more nuanced understanding of the South African COVID-19 lockdown. The target population was categorised into the following sectors: the community sector, the public/civil society sector and the private sector (see Fig. 1) (Schmidt et al., 2020).

Representation of diversity in qualitative research is informative and useful (Allmark, 2004). Study participants were identified from various socio-cultural and economic backgrounds within Gauteng, KwaZulu-Natal and the Western Cape provinces. Eligible participants were 18 years of age or older.

In total, we conducted 60 key and community informant interviews. One focus group discussion was conducted remotely with 5 staff members managing an old age home in KwaZulu-Natal. Semi-structured interviews were conducted with taxi owners/drivers/commuters (n = 6); community health workers (n = 6); faith-based leaders (n = 3); traditional leaders (n = 2); educators (n = 3); sex workers (n = 2); people living with HIV (n = 3); a person living with a chronic condition such as diabetes mellitus (n = 1), representatives of sexual- and gender-minority groups (n = 4); relief aid workers providing services to homeless people (n = 2); relief aid workers providing services to migrant communities (n = 5); people with disabilities (n = 6), patrons of *shebeens* (informal licensed drinking establishments) (n = 5); out-of-school youth (n = 6); airport workers (n = 3); a pregnant woman (n = 1); and with old age home carers in Gauteng and the Western Cape (n = 2).

### 2.3. Data collection and tools

Data collection was conducted from 5 to 18 April 2020. With the onset of the COVID-19 pandemic, as per regulations set by the Research Ethics Committee (REC) of South Africa’s Human Sciences Research Council (HSRC), all non-interventional research with human participants was suspended or switched from face-to-face to remote (i.e., on-line, telephonic) data collection. Telephonic interviews were used to collect data in this study. The ethically approved study information sheet and consent forms were either emailed or sent to participants via WhatsApp. Before the start of the interview, informed consent was obtained verbally from all participants. After having read and understood the contents of the study, the participants chose their own pseudonyms. Verbal consent to participate in the study was audio-recorded as part of the interview process. On average, telephonic interviews lasted approximately 30–45 min.

Semi-structured interview guides were used to conduct key and community informant interviews. The interviews explored the following

themes: (i) basic knowledge regarding the spread of COVID-19; (ii) sources of information about COVID-19; (iii) myths, misconceptions, false information about the spread of the disease; (iv) notions of vulnerability; and (v) perceptions/experiences of the lockdown and social distancing. Interview questions were structured to elicit participants’ knowledge and sources of information, and their vulnerabilities and perceptions/experiences of lockdown/social distancing. The guide used phrases such as “do you”, “would you”, “what are your”, “how are your”, etc. One question was asked about myths/misconceptions in the community at large, but throughout the interview, where the informant revealed a myth/misconception that they held, the interviewer probed to gain further insight.

Interviews were conducted and audio-recorded in English, isiXhosa, isiZulu and Afrikaans as the predominant languages in each of the three provinces.

### 2.4. Data analysis

All interviews were transcribed verbatim and translated into English by investigators who were part of the study. Data were de-identified during the translation and transcription process.

Atlas.ti.8 was used to facilitate data analysis. The principal (PI) and co-principal investigators led the analysis. The qualitative data analysis consisted of the following steps: i) reading and re-reading each transcript; ii) marking the transcripts with a code label; iii) coding the text using open coding to capture participants’ exact words and phrases and to avoid preconceived notions or classification; iv) standardising the coding by applying labels such that the PI could identify topics/themes/ideas; v) creating a coding list comprising 129 unique codes; vi) grouping together and categorising several codes; and vii) comparing codes and categories to generate analytic schema and interpret the findings.

### 2.5. Dissemination of study findings

The results were disseminated to the Minister of Higher Education; the President of South Africa; and the National Coronavirus Command Council comprising cabinet ministers and the National Joint Operational and Intelligence Structure Committee. The Minister of Higher Education and the South African public broadcaster then launched the findings live on digital platforms. The session was interactive and the Minister and HSRC representatives answered questions raised by the general public. After these presentations, the information was disseminated widely through TV and radio interviews, via news platforms and during several webinars (Reddy et al., 2020a).

Community sector	Public/civil society sector	Private sector
<ul style="list-style-type: none"> <li>• Out of school youth</li> <li>• Immunocompromised groups</li> <li>• Sex workers</li> <li>• People living with HIV</li> <li>• People with chronic conditions such as diabetes mellitus &amp; hypertension</li> <li>• Sexual and gender minority groups</li> <li>• People with disabilities</li> <li>• Pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Community health workers</li> <li>• Caregivers of elderly people in old age homes</li> <li>• Relief aid workers providing services to:                             <ul style="list-style-type: none"> <li>• Homeless people and;</li> <li>• Migrant communities</li> </ul> </li> <li>• Educators</li> <li>• Faith-based leaders</li> <li>• Traditional leaders</li> </ul>	<ul style="list-style-type: none"> <li>• Mini-bus taxi sector</li> <li>• Operators</li> <li>• Commuters</li> <li>• Taxi drivers</li> <li>• Shebeen sector</li> <li>• Owners</li> <li>• Patrons</li> <li>• Airport workers</li> </ul>

Fig. 1. Target population.

## 2.6. Ethical considerations

Ethics approval was obtained from the HSRC's REC (Protocol No REC 5/03/20). Overall, there were minimal expected social harms and risks to participants. One risk was that study participants would feel uncomfortable responding to some of the questions. Another risk was that someone outside the study would overhear the interview. We asked participants to ensure that there would be little to no disturbances during the interview because the interview would be recorded. For the duration of the interview, we asked participants to position themselves in a space where they could remain undisturbed by other members of the household throughout the telephonic interview.

At the end of each interview, we shared toll-free numbers and links to websites where participants could access correct information about COVID-19. Participants received reimbursement to the value of ZAR30 airtime as a token of appreciation for their time and participation in the study.

## 3. Results

The following themes were found to be recurrent in the data and are presented in the following manner: i) Fear of infection; ii) Living under the lockdown; iii) Food and income insecurity and iv) Social responsibility, resilience and social cohesion.

### 3.1. Fear of infection

Social and physical distancing and country-wide lockdowns are proven and necessary measures to contain the spread of SARS-CoV-2 (National Department of Health, 2020c). However, these containment measures are challenging for many South Africans living in already impoverished communities. Sub-economic housing, overcrowding, poor sewage systems and high unemployment rates characterise many South African townships. The deep-rooted structural inequalities in South Africa that exist along the lines of race, gender and class were exacerbated during the 21-day stay-at-home lockdown. Concerns raised in interviews included the ability to self-isolate during quarantine in overcrowded informal settlements, or how social distancing was maintained in overcrowded minibus taxis:

*"Most of them come from informal settlements and there is [no] distance between [houses and shacks]. The taps that they use is one common tap for 20 other people. The water that they use ... we are not sure if it is clean enough for them to use because there are so many other people using it."*

(Educator, KwaZulu-Natal)

With the onset of the pandemic, many South Africans were forced to choose between purchasing masks and hand sanitisers as precautionary measures or purchasing daily essentials such as bread. The lack of availability of masks in the early days of the outbreak increased fears and contributed to feelings of hopelessness, fuelling confusion and panic:

*"For me, it has caused a lot of panic ... we do not know ... what to believe. Others say this and others say that ... it has caused a lot of confusion. You see now, once you cause confusion, a lot of things will be at a standstill because people won't see the way forward. So, it's been very damaging. Things are at a standstill, from work to school. When everything is at a standstill, even production is affected .... It's going to be hard; it's going to be hard."*

(Sexual- and gender-minority group representative, Gauteng)

*"The fear will kill me before this virus."*

(Old age home carer, Western Cape)

Not only has the lockdown made visible the social and economic

inequalities inherent in South Africa, but the fear of infection has also led to emotional trauma in already impoverished communities.

### 3.2. Living under the lockdown

Being robbed of "[their] lives" captures the effect of the COVID-19 pandemic on the human, social and economic capabilities of South African communities. In the words of this community health worker (see quotation below), life as people knew it no longer existed. Even though the below quotation highlights how the pandemic affected the lives of school-going learners and university students, it also points to the overwhelming feeling of hopelessness, so much so that the practice of everyday life is no longer possible.

*"Our lives are ... it is like it has come up and stole our lives from us. We had plans, now we cannot continue with that. The kids at school, the universities, they can't continue with their lives."*

(Community Health Worker 1, KwaZulu-Natal)

Living under the lockdown presented specific challenges for vulnerable and marginalised communities, according to this relief aid worker:

*"Yes, obviously like on lockdown day [the homeless people] who were [at the shelter] [were kept there]. We tried to get new people [in] but they won't take any, like we found all the services, sub services, in-patient programs for mentally ill, everybody locked their door and said we are not taking anyone."*

(Relief aid worker for homeless people, Western Cape)

As is evident from the above quotation, vulnerable groups such as homeless people were further marginalised as operations and services were restricted or shut down.

It was also evident that the majority of South Africans were able to adhere to the containment measures put into place during the 21-day stay-at-home lockdown (Reddy et al., 2020b); however smaller acts of non-compliance were observed.

*"In my community, they don't take [the lockdown] seriously because ... people are always around each other. I had to call the police last week because [there were] these guys who played those gambling cards. So, they will be gathering there up to 40 playing those cards and what I saw in my community is that they not taking it that seriously. They are always walking; the police have to come out and chase them."*

(Sex worker 2, Gauteng)

Alcohol was not considered an essential good or item during the lockdown (National Department of Health, 2020a). Alcohol sales and consumption have been shown to be linked to violent crimes, road accidents and other causes of medical emergencies (National Department of Health, 2020a). Hence, during the stay-at-home lockdown, the selling and purchasing of liquor (and nicotine) were banned to ease potential strain on the healthcare system as the number of SARS-CoV-2 cases increased in South Africa. This, however, posed an issue in communities as some community members suffered withdrawal and others continued selling alcohol illegally:

*"We are told to stay indoors. And, here, the people are going down the street, others taking things, drinking alcohol, you see, all [of] those things they said we must avoid."*

(Person with disability, KwaZulu-Natal)

### 3.3. Food and income insecurity

“... As a mother, [pause] you worry a lot. I have not been sleeping much because you do not know [what] tomorrow will bring. It [the lockdown] is going to be extended, you know. Those kinds of worries that you as a breadwinner ... will experience.”

(Person living with HIV, KwaZulu-Natal)

South Africans' fears echoed those expressed in other parts of the world, that the lockdown would severely damage the economy and cause or worsen poverty and hunger in many households. This applied particularly to those working in the informal sector and on contract bases, as they had no protection. South Africa is classified as an upper middle-income country with high unemployment rates in specific populations, such as young men who have restricted opportunities for work in the formal sector (Matandare, 2018). High unemployment and low education levels are legacies of the *apartheid* past (Altbeker & Storme, 2013; Statistics South Africa, 2019). The informal economy includes small, unregistered businesses that are seldom run from business premises. Instead, they are run from homes, street pavements and other informal arrangements (Devey et al., 2011; Skinner, 2006). For many South Africans, income generated in the informal economy is the primary source of income. For instance, the informal minibus taxi industry has suffered financially because of the 21-day stay-at-home lockdown:

“As it is, it [the lockdown] is costing us an arm and a leg in the taxi industry which we provide everything ourselves and there is less income anyway.”

(Taxi Owner, KwaZulu-Natal)

Moreover, for many in the informal sector, casual work is the only source of income. Casual work opportunities and street vending were not allowed during the lockdown, causing many to suffer:

“Obviously, there is no income and I am already worried that when the lockdown is over, I wonder where I will work. I wonder if they are going to pay me or [if] I am just going to lose everything because of this lockdown that I did not plan for.”

(Person living with HIV, KwaZulu-Natal)

During the stay-at-home lockdown, the government made provision to distribute food parcels to those who were in social and economic distress. However, the promise of food parcels seemed unattainable for those in poverty-stricken situations:

“You must understand that now that the lockdown is on, no one is working, and so food is becoming the [biggest] problem in the community. [Our] HIV patients, [our] TB patients, our patients cannot afford [to miss their medication]. They [are] trying to see where they get food so that they can have the medication and the food at the same time. So, [these] are big issues [and] why people are not abiding [by] the rules.”

(Community Health Worker 2, KwaZulu-Natal)

In a social context where communities were already suffering due to existing social and economic inequalities, poor communication and implementation strategies for distributing food parcels made the impact of the stay-at-home lockdown more traumatic:

“Here they were talking about the food parcels. It is such a long process that a person must go through. I called the person on the phone. He was very nice, he explained to me from A to Z what I could do to get the food parcel, and if government does not feel that you need the food parcel, the government will not give it to you. Not one person who applied for this received the parcel.

(Person living with HIV, Western Cape)

Similarly, relief aid workers were concerned that migrant communities struggled to pay for rental housing. Food insecurity and fears related to an unknown disease added to the trauma brought on by the pandemic (Cloete et al., 2020).

“It’s very difficult and I don’t know what we are going to do month-end and we don’t know about the rent with regard to the landlord so at least we manage to to buy food but the rent we don’t know if ... I am not sure about the lockdown will be extended. If it is extended [it] is not gonna be good because people are suffering so at least if they can allow people to go and sell stuff to survive so now they can have money to [survive] during [the] lockdown.”

(Relief aid worker providing services to migrant communities, Western Cape)

### 3.4. Social responsibility, resilience and social cohesion

The COVID-19 lockdown had social, psychological and economic effects on the lives of South Africans from diverse backgrounds. Yet, the metaphor of the rainbow nation was invoked as South Africans appeared united in their response to the South African government’s appeal to flatten the infection curve:

“I think if everybody takes this seriously with the true sense of nationalism and the love of their country the private sector should be working hand-in-hand with the government in order to help provide resources like the nurses and the frontline workers and as has being done in little pockets much more is needed.”

(Person living with a chronic condition such as diabetes mellitus, KwaZulu-Natal)

The South African government’s swift and scientific response to the management of the pandemic appeared to have restored confidence and trust in its ability to manage such disasters, including the related social distress (Zanker & Moyo, 2020).

“Eish I am taking it serious because if it was not serious the President wouldn’t have said let’s have a lockdown and stay home indoors for something that is not serious.”

(Shebeen patron, Western Cape)

“I make sure that no one at my family goes to gatherings. I teach them everything. I make sure that they understand. Whenever I see something on social media I read what is being posted by the government because I don’t believe anything posted by people now. Anything posted by the government I share it with my family so that they can understand better and do what the government is saying.”

(Community Health Worker, KwaZulu-Natal)

In times of social and economic distress, the ability to draw from existing social support structures is a fundamental building block for maintaining a healthy sense of wellbeing. With the onset of physical and social distancing and the subsequent lockdown, these social support structures were no longer readily available. Nevertheless, a narrative of social responsibility towards those who have suffered from food and income insecurity has emerged:

“For instance, this weekend we went to Matatiele [local municipality located in the Eastern Cape province of South Africa] giving food parcels and advising people on what to do. We were going house to house. Especially those houses that we identify as people who are poor and destitute – where no one is working – when we are there, we talk about it ...”

(Traditional Leader, Gauteng)

“A lot of our groups are doing seva.<sup>1</sup> We call it seva. They [are] making hampers; they [are] giving out. They [are] doing their part, whatever they could; they [are] doing their part. Everything revolves around money; that is our biggest problem.”

(Taxi Owner, KwaZulu-Natal)

Hence, in the first 21 days there appears to be some evidence that in times of social upheaval, as was brought on by the COVID-19 pandemic, various sectors of South African society work together to build community resilience. A unified and committed society is crucial for recovering from the social and emotional upheavals caused by the COVID-19 pandemic and the consequent lockdown.

#### 4. Discussion

With the outbreak of the COVID-19 pandemic in South Africa, our qualitative findings illustrate that social inequalities were exacerbated.

According to Ahorsu et al. (2020), fear is a typical response to infectious disease (Ahorsu et al., 2020). We found that with the implementation of the lockdown, fear of infection emerged across different sectors of South African society. In our study, the containment and experience of isolation during the COVID-19 pandemic and lockdown created an inimitable and severe strain on people’s ability to maintain a hopeful outlook (Cullen et al., 2020). The fear of infection was compounded by concerns regarding the inability to self-isolate in overcrowded informal settlements; or how social distancing would be maintained in overcrowded minibus taxis. Pandemics become traumatic when people must choose between purchasing masks and hand sanitisers as precautionary measures or daily essentials such as food. The lack of availability of masks in the early days of the outbreak increased fears of infection. Fear of contacting individuals who are possibly infected by SARS-CoV-2 has been reported elsewhere (Ahorsu et al., 2020; Lin, 2020). Unfortunately, fear may amplify the damage of the disease itself (Ahorsu et al., 2020). According to Guan et al. (2020) and Huang et al. (2020) the COVID-19 pandemic has exacerbated fears worldwide leading to stigma in some cases (Ahorsu et al., 2020; Lin, 2020; Schmidt et al., 2020).

With the advent of the COVID-19 pandemic and the consequent stay-at-home lockdown, those who were previously able to impress a sense of dignity through casual and informal labour were no longer able to escape their daily lived realities. With the continued lockdown, specific stressors may have increased, which include having inadequate supplies, food, resources, difficulty securing medical care and medications, and financial losses due to unemployment (Pfefferbaum & North, 2020). People stood in long queues to collect food parcels (Lockdown, 2020) and, in some instances, trucks delivering food relief were hijacked and looted (Tau et al., 2020). In addition, incidents of corruption have been reported in eight of South Africa’s nine provinces. Claims included allegations that those in charge of the distributions – mostly community councillors – were not giving the food to the families that were most in need (Tau et al., 2020). Government officials were accused of selling food parcels or unfairly distributing them to their political party members (Moche, 2020). The South African government, in particular President Cyril Ramaphosa, has come under scrutiny for its slow response to the prosecution of political officials’ involvement in fraud and the unfair distribution of food parcels meant for the poor during the ongoing lockdown (Malala, 2020).

Societies confronted with constant crises experience immense inequalities; and levels of trust are generally low (Eriksen, 2020). However, according to Ndebele and Sikuza (2020), in South Africa, the response to COVID-19 has seen people across all sectors coming together

on a large scale to mitigate the harm through relief funds for businesses, the setting up of shelters and food parcel schemes, as well as an increase in existing social grant provisions (Ndebele & Sikuza, 2020). Despite the social distress experienced by our study participants, there was evidence of social responsibility towards those who were most affected by the lockdown. South Africans have rallied towards those individuals, families and communities and have provided social relief to those in need.

According to Mamanzi (2020), in South Africa, the COVID-19 pandemic has seen the revitalisation of the values-based philosophy of African humanism, *ubuntu* (Mamanzi, 2020). Literally translated, *ubuntu* means: “a person is a person through others” (McDonald, 2010). According to the University of Johannesburg-HSRC COVID-19 Democracy Survey, which was conducted between 13 April and 11 May 2020, almost half of the respondents were optimistic that the crisis would lead to greater social solidarity (48%) while 28% felt it would create further division in society (Roberts et al., 2020). According to Roberts et al. (2020), this outlook was consistently observed, irrespective of the wide range of socio-demographic attributes examined (Roberts et al., 2020). However, this “ubuntu moment”, according to Roberts et al. (2020) appears to have been short-lived, with South Africans adopting a more sceptical outlook during the latter part of the lockdown level 3 in July 2020 (Roberts et al., 2020). According to the researchers, “the proportion who felt the pandemic would unite South Africans fell by 14 percentage points between the two survey rounds, whereas the pessimistic view grew by 17 percentage points” (p.1) (Roberts et al., 2020). Thus, the leading view became one of division rather than solidarity (45% vs 28%), “signifying that a generalised scepticism emerged among South Africans between the initial hard lockdown period and the subsequent, less restrictive, lockdown phase” (p.1), according to Roberts et al. (2020) (Roberts et al., 2020).

Qualitative data revealed that smaller acts of non-compliance to the lockdown occurred across South African communities. These smaller acts of non-compliance often centred on obtaining alcohol illegally. In South Africa, research shows that alcohol abuse is the most harmful drug at a population level (Peltzer & Pengpid, 2018). According to Matzopoulos and colleagues (2014), alcohol abuse is the third-largest contributor to death and disability after unsafe sex/sexually transmitted infections and interpersonal violence, both of which are themselves influenced by alcohol consumption (Matzopoulos et al., 2014). Our qualitative data suggest that despite the alcohol ban, this did not deter community members from purchasing alcohol. However, it should be noted that the alcohol ban resulted in fewer alcohol-attributable hospital admissions, providing relief on South Africa’s healthcare services and reducing pressure on emergency care units and lowering mortality (Reuter et al., 2020).

Purposive sampling was limited to the provinces included in the rapid assessment. Key and community informants were primarily recruited through organisations, CSOs and contacts made by the researchers. Hence, the method of sampling led to the selective inclusion of individuals who have established networks and ties with the HSRC. The results apply only to the sample of key informants and community members who took part in the assessment. Hence, the findings are not representative of all people living in South Africa or even those living in the three provinces. Telephonic interviews are proven data collection methods. However, body language is often relied on when engaging in qualitative interviews but not possible when conducting telephonic interviews. Moreover, when conducting telephonic interviews, access to key visual contextual data limits the ability to establish rapport between study participant and researcher (Farooq & De Villiers, 2017).

Despite these limitations, this study brings attention to the unique challenges faced by different sectors of South African society during the 21-day stay-at-home lockdown. Most notably, qualitative data point to concerns of self-isolation in overcrowded homes located in townships; the challenge of maintaining social distance in overcrowded minibus taxis, and how family members would care for each other, and self-quarantine in one-room dwellings. It is vital to understand how good

<sup>1</sup> Seva refers to the Hindu practice of collectively offering help or assisting the community (Srivatsan, 2019).

prevention and control practices can be maintained in these living conditions.

## 5. Conclusions

The fear of an unknown disease is traumatic for families, households and communities. The potential to overcome the social distress brought on by the COVID-19 pandemic and the consequences of the lockdown lies in engaging meaningfully with communities in the management of the disease. Despite the social distress brought on by food and income insecurity, different sectors of South African society have united to ease the pain and suffering of the poor and impoverished. The social responsibility and social cohesion demonstrated by different sectors should be drawn on to invoke community resilience, even in the absence of physical proximity. Thus, making use of a community participatory approach will help to alleviate increased fears of infection and other life altering challenges such as those brought on by the South African COVID-19 lockdown. A community participatory approach should endeavour to engage all sectors of South African society, in mitigating unintended consequences of the COVID-19 containment measures. Affected, vulnerable and disenfranchised groups and communities should be included in the South African government's response to the COVID-19 pandemic. In this way, community organisations and CSOs can play a critical role in not only alleviating social distress but also communicating the medical and public health response in the further management of the disease to all sectors of South African society. Overall, meaningful engagement with different sectors of South African society is critical in any future measures to contain the spread of SARS-CoV-2. More importantly, the government should engage all sectors of South African society about the implementation and planning of any future social assistance programmes in alleviating the social distress brought on by the COVID-19 pandemic.

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## CRedit authorship contribution statement

**Allanise Cloete:** Writing – original draft, Methodology, Software, Validation, Formal analysis, Data curation, Writing – review & editing. **Alicia North:** Writing – original draft, Writing – review & editing. **Shandir Ramlagan:** Methodology, Software, Validation, Writing – review & editing. **Tenielle Schmidt:** Writing – review & editing. **Lehlogonolo Makola:** Writing – review & editing. **Jeremiah Chikovre:** Writing – review & editing. **Donald Skinner:** Writing – review & editing. **Sasiragha Priscilla Reddy:** Conceptualization, Supervision, All authors have read and agreed to the published version of the manuscript.

## Declaration of competing interest

The authors declare no conflict of interest.

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