‘Closing the Gate’

The State and the People in Rural South Africa in the Time of COVID

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Abstract

The article explores the interaction between the South Africa state and rural communities in the Eastern Cape Province of South Africa following the outbreak of the COVID-19 pandemic in 2020.[1] It suggests that the state adopted a particularly repressive lockdown strategy in the former homelands or rural areas because it feared that customary practices, like male initiation, and rural funerals would emerge as potent ‘super spreaders’ of the COVID-19 virus.[2] The heavy-handed clampdown that followed took rural communities by surprise and created a culture of fear and panic, as many wondered why the state was ‘closing the gate’ on their homesteads, their culture and communities in a time of crisis. This feeling was exacerbated with the collapse of the provincial health service during the first and second waves of infection in 2020 when clinics, hospital and government departments closed across the province for deep cleansing, strike action or due to the lack of medicine and equipment. This entrenched fear and the sense of exclusion and victimisation in rural areas. In 2021, with the arrival of vaccines, the Eastern Cape government was mandated to vaccinate a substantial proportion of the provincial population within a year. Suddenly, the gate opened as the provincial government now sought to communicate with rural people and win popular support for its vaccination drive. The article explores how the gate closed on rural communities in the Eastern Cape within a wider discussion of pandemic politics and state control, on the one hand, and the challenges associated with the emergence of more democratic forms of public health, or what Richards calls ‘people science’ on the other.[3]

Introduction

In rural South Africa, funerals are family and community affairs. They are not usually managed by the state, funeral directors, local government officials or hospital staff. They are not occasions at which one expects to find health officials and funeral directors dictating behaviour or policemen threatening arrests and fines. Families and religious leaders are normally given relative freedom to bury the dead in dignified ways, according to tradition and religious belief. In the time of COVID-19, however, funerals and other customary practices, such as male initiation rites and other community rituals, became identified as high-risk sites of infection, especially in rural areas where a disproportionately large number of these rituals still occur in South Africa. They were viewed by the state as 'super-spreader' events that needed tight management, control and monitoring.[4] The regulations for funerals produced in April 2020 sought, among other things, to restrict travel between provinces, govern interaction with COVID-19 infected bodies, enforce sanitising and physical distancing, restrict attendance at funerals, shorten rituals, and limit the preparation of food and alcohol at these events for collective consumption. In addition to these measures, large-scale gatherings and a number of customary practices in rural areas were also banned during lockdown.

In the gap between cultural observance and statecraft, customary practices and funerals quickly became a major target for law enforcement in the fight against COVID-19 in rural South Africa. The assumption was that rural communities were likely to ignore state regulations and so it needed to be shown – in no uncertain terms – that the state meant business when it came to containing the spread of COVID-19. To demonstrate their commitment to implementing the COVID-19 regulations, the police force swept across the Eastern Cape region closing down customary gatherings, especially initiation schools, and disrupting funerals during March and April. Where they found gatherings of more than 50 people at funerals, situations where social distancing was not observed, or events where food and beer was obviously being consumed communally, the police tipped over drums of traditional beer, pots of food and sent people home.[5] The repressive response of the police and the state to the threat of the coronavirus in rural areas created a culture of fear in rural communities, which was later entrenched when many rural clinics and hospitals were forced to shut down at the height of infections in June and July 2020 due to a lack of personal protective equipment (PPE), the absence of deep cleaning protocols and a rapid increase in infections.[6]

In the rural Eastern Cape, individuals and communities often spoke about the COVID-19 period as an experience where the state 'closed the gate' (*ukuvala isango*) on them, shutting them out, and bullying them at a time of great fear and uncertainty.[7] The aim of this article is to throw light on the impact of the state's lockdown regulations and restrictions on funeral practices in particular on the lives and dignity of rural communities in the former Transkei region in the Eastern Cape. The paper highlights the trauma and distress caused by a 'war on COVID' in rural South Africa which was implemented through a tough, top-down, one-size-fits-all biomedical lockdown regime implemented by the state to arrest the spread of pathogens but with little or no sensitivity to the social needs and cultural rights of the local communities. In the presenting this material, the paper also highlights the absence in South Africa of what Paul Richards has

called the emergence of 'people science' under conditions of mass infection, such as occurred with the Ebola virus in West Africa in the early 2010s. For Richards and others sympathetic to this approach,[8] 'people's science' develops when the biomedical science on contagion and transmission is shared and internalised in a local setting to the extent that ordinary people are empowered to instigate and internalise new forms of everyday behaviour that mitigate against the spread of the disease, while maximising the potential for long-term safety and prevention. The paper argues, while a more community engaged approach emerged in rural South Africa with the role out of vaccinations in 2021, the initial phases of COVID management were defined by a heavy handed, top-down and authoritarian approach that frightened and alienated rural communities.[9]

Pathogens, State Power and 'People's Science'

In his 2021 book, *New Pandemics, Old Politics: Two Hundred Years of War on Disease and Its Alternatives*, Alex de Waal argues that, while the dominant discourse around chronic diseases, such as diabetes, centres on citizen responsibility, infectious diseases have generally allowed states to claim the initiative and mobilise a discourse of war in the name of protecting citizens from the external threat of pathogens.[10] This approach empowers states and potentially diminishes the possibilities for democratic public health, invoking a special kind of biopolitics.[11] The Italian philosopher Giorgio Agamben argued that, when the COVID-19 virus raged through Italy in March 2020 and the Italian state enforced extreme lockdown measures on the population, they deliberately created a 'state of exception' where citizen's rights and freedoms were compromised. He suggested that the authoritarian measures taken to confront the pandemic undermined democracy and could lead to fascism.[12] Others disagreed, saying that such measures were necessary and only short-term. But in his book, De Waal shows that this has seldom been the case historically as the increased state authoritarianism that comes with new pandemics as the same 'old politics' which lingers long after the panic around the pandemic subsides.[13]

In South Africa, the pandemic arrived at a time when corruption and political factionalism within the ruling African National Congress (ANC) was undermining the legitimacy of the ruling party and the state. The COVID-19 crisis thus provided an opportunity for the ruling faction within the party, under President Cyril Ramaphosa, to seize the initiative, declare war on the pathogen and design a rational health-centred, welfarist response from the state. The Disaster Management Act of March 2020 was deployed to declare a state of disaster and a Ministerial Advisory Committee (MAC) of high-level medical experts and scientists was appointed to advise the president on the changing nature of the threat and the measures needed to contain it. In the absence of hi-tech surveillance or reliable community-level structures to assist the state with monitoring and surveillance, the response was centralised in the Office of the Presidency and framed as a universal set of measures for all citizens, rich and poor, urban and rural. A military-style, National Coronavirus Command Council was also established and the provinces were required to submit regular updates and reports to the Minister of Health, Zweli Mkhize, the MAC and President Ramaphosa.

In his speeches, the President stressed that the success of the tough lockdown regime would rest on citizen compliance, which made it necessary for the police and army to assist with implementation across the nation. In the Eastern Cape, over 100 000 people were arrested in the first month after the state of disaster was declared in March 2020, most of which occurred in rural areas.[14] The state assumed that traditional rural communities would be the least willing to comply with the new COVID-19 regulations. So, to ensure that the cultures of the rural communities did not threaten national health, the ruling party banned customary practices and planted police at rural funerals across the province to ensure that rules for sanitising and social distancing and restrictions on attendance were enforced. The state clearly assumed that urban middle- and working-class communities would be more likely to comply with the rules than rural communities and was thus determined to send a strong message in those areas: Obey the state, act like self-disciplined modern citizens, or face the consequences![15]

In his book, Alex de Waal argues that the hegemonic discourse of war on pathogens, which builds and sustains authoritarian states, never succeeds in fully overcoming the threat of infectious disease, even in cases where effective vaccinations are developed to stop viruses from spreading.[16] The pathogens survive and continue to spread, while the actual conditions that created the disease in the first place are never addressed. Longer-term, sustainable solutions to the recurring crisis of infectious disease, De Waal insists, require more democratic and inclusive systems of public health, community engagement and knowledge-sharing about the causes and containment of disease. This cannot simply be an issue of state-enforced interventions to minimise biological transmission, maximise individual self-regulation and pursue a curative solution in the form of a vaccine. Such a limited approach entrenches the power of the state and strips public health of its social context because diseases are transmitted, understood and experienced within a wider ecology of social relationships, practices and beliefs. De Waal argues that the failure of states to generate a situation where consensus can be reached through the open exchange of ideas, limits the efficacy of sustainable, longer-term interventions. Without engagement and the co-production of new knowledge and the adoption of joint strategies, De Waal says, people inevitably go back to the same destructive behaviours that produce pandemics in the first place, which also limits the efficacy of vaccines in their capacity to remove the threat of disease.[17]

Paul Richards has called this process of the co-production of knowledge 'people's science'. This is not the same as indigenous knowledge but draws on local knowledge and biomedical research to develop locally meaningful and grounded responses to the threat of epidemics or pandemics. He argues that in Africa the potential of people's science is hugely underestimated because Western medical experts fail to recognise the capacity of local people to adjust their behaviour in relation to new evidence. They also tend to view local cultural beliefs and social practices as dangerous to disease transmission rather than an opportunity through which more effective and democratic preventative practices can be crafted.[18] In the case of Ebola, Richards found that, once local communities in West Africa had engaged openly with international medical experts, NGOs and government officials, and realised that the diseased Ebola bodies were highly infectious and that transmission spread through touching and cleaning bodies, they were quite prepared to change their home-care regimes and funeral practices to minimise

the risk of infection and transmission. This allowed homes and villages to be transformed into safer spaces and made a massive contribution to the containment of Ebola in West Africa, where formal state health infrastructure, like hospitals and clinics were and are in short supply. In short, by democratising the practice of prevention and disease control, the capacity for control and prevention was improved and ultimately containment became possible. In the West African case, the weakness of states to enforce a local or national 'war on Ebola' through their own public health systems and their reliance on international bodies like the World Health Organisation (WHO) and especially *Medecins Sans Frontieres* (MSF), who were prepared to engage in more open exchange with local communities, seems to have gradually created the space for a co-production of locally appropriate responses, which Richards argues created a bulwark of community practice across the region that kept the Ebola epidemic in check.[19]

The response to COVID-19 in South Africa has been quite different. The national government followed the northern modernist, strong-state model by activating a 'war on COVID', in which local cultural practices were deemed dangerous and deviant and in need of being curtailed or suspended in favour of the implementation of a universal code for individual behavioural adjustments based on biomedical science. The national president and health minister were led in their decision-making by team of medical scientists and biomedical experts, who were generally following global science and international best practices, rather than engaging with local social scientists, civic organisations, and cultural leaders in forging their behavioural prescriptions. By the end of April 2020, there were still no social scientists, cultural specialists, religious leaders or community representatives on the MAC;[20] and yet a great deal of what the committee proposed in the opening months of the COVID crisis was the enforcement of a suspension of cultural practices. In line with this approach, the government deemed funerals to be 'super-spreader' events which could only take place with restrictions on the numbers attending, the management of the ritual and the handling of the body. The rules stated that the bodies of the deceased should not be engaged by family or mourners and should be wrapped in plastic to prevent infection among immediate family and relatives, who might be inclined to touch or wash the corpse at home before placing the coffin in the earth. In the course of 2020, and especially as the rates of infection increased, the state and its scientific committee remained adamant that the bodies of the deceased were on the most dangerous elements at funerals and that they should be sealed and protected from mourners.[21]

This discourse of the body had a profound impact on the way in which funeral parlours operated and set out to protect their own workers, who handled dead bodies every day. To avoid unnecessary infection, it was agreed between the state and funeral parlours that bodies should be wrapped in multiple layers of plastic when they left the mortuary and should only be delivered to the gravesite on the day of the funeral and not before. In some provinces, such as the Eastern Cape, it was additionally decided that all bodies should be tested to determine whether they were COVID-19 deaths or not. At the same time, families who hosted funerals were required to keep attendance registers and offer sanitising stations and appropriate spaced seating to allow the events to meet government standards. Funeral services were also to be no longer than two hours, during which time the body would arrive and be deposited at the gravesite by the funeral parlour workers. The practice of holding night vigils at which the family would engage with the

deceased were strictly banned as was the practice of the body lying at rest in a tent where the funeral service was held and where people paid their last respects. While the regulation of rural funerals and customary practice was necessary, the top-down and oppressive manner in which the regulations were implemented proved to be highly problematic since it created a culture of fear and panic rather than a platform for collaboration and communication. In what follows we provide a narrative account of the dual crisis of the shutdown of customary practices and the simultaneous collapse of the provincial health service, before returning to the broader questions raised about pandemic politics and people's science. We argue that the management of the pandemic has pitted rural people against the state, which now has consequences as vaccine up-take in rural areas seems to have hit a glass ceiling at less than 50 per cent of the adult population.

Closing the Gate: The Culture of Fear

In April 2020, community representatives across the former Transkei reflected on cases where the police had interfered in family funeral and customary rituals. They were extremely critical of what they considered to be a repressive campaign of intimidation by the state. One traditional leader recalled a case that was brought to his attention, in which the family were presented with a dilemma: either obey the rules of the state or honour the wishes of the deceased family patriarch:

> During the beginning of the lockdown, people were afraid of the police and the military army. There was a household where the grandfather died, and while he was still alive, he said to the kids that during his funeral they should slaughter a cow and eight sheep. And they [the children] did exactly that to pay respect to their father's wishes. Many people went to that funeral, but the police came and chased them away. They said that only 50 members should attend. I believe that those family members knew about the rules, but they felt that the spiritual consequences of not obeying their father were greater than not obeying the police. It is our culture that people are always afraid of not respecting the wish of the dead people. They consider that as causing bad luck and misfortune in the family.[22]

Social media coverage also indicated significant conflict between local people and police at funerals. At one funeral in Engcobo, police were reported to have acted violently, turning over pots with cooked food, meat and *umqombothi*, the African home-made beer which is brewed as part of the funeral rituals. They also chased away mourners to keep the numbers down. Later on the same day, a police car carrying officers from the Engcobo funeral overturned on the road – which was interpreted as an act of vengeance by the ancestors, punishing the police for failing to respect the precepts of their own African culture at the funeral earlier.[23]

In another complaint against the police, one respondent from the Centani area complained because the 'local authorities and police would not allow the body, which had arrived from Cape Town, to enter the main house or the funeral tent'. They reported that the authorities insisted that the body had to remain outdoors and be put in the ground as soon as possible. This caused

great concern for the family and relatives, who proclaimed that the deceased could not pass on to the next world under such stressful conditions and without communicating with the immediate family.

The clampdown by the police in the rural Transkei was part of a national campaign by the South African Police Service, sending out a message from the government that the lockdown measures were not optional. One traditional leader from the same area explained that 'there was a funeral at a neighbour's house, where more than 100 people gathered'. The authorities took exception and raided the venue while the traditional healer was still in communication with the deceased. He explained: *ndithe ndisathetha uba lomfana lo ndiyamazi, kwathwa nanga amapolisa ndathi Haibooooo, sabaleka sonke* – 'I was still talking about the deceased and someone shouted: "Police! Police!" And the law enforcement officials entered, and we all ran away.' The traditional healer said that the unannounced raid by the police had undermined the process of communicating with the deceased and had threatened the legitimacy of the funeral.

The police wanted rural communities to realise that the regulations were compulsory and they seemed intent on instilling a climate of fear. The message was that those who did not obey the new rules would soon find themselves in jail.

Over the Easter weekend, many were offended by the way the police were behaving in the rural areas, chasing people away from ceremonies and turning over drums of home-brewed beer. The communities said that they had not been consulted and that there had been no public education about the nature of the coronavirus and the risks associated with it. It was also noted that there had been little communication among national, provincial and local officials on how to manage communities in rural areas. As the cloak of lockdown enveloped rural communities, many felt as though they were in a Tower of Babel, surrounded by the noise of new regulations and required changes in behaviours, but little clear, credible information and advice. The police were following their instructions to enforce the regulations and disperse large social gatherings, while the traditional leadership in the province independently announced that male initiation and customary ceremonies would be suspended until further notice in 2020.

At the end of April, it was reported that 40 people had tested positive for COVID-19 in the village of Machibini in the Port St Johns area of the former Transkei.[24] The state claimed that the evidence suggested that the Machibini cases could be tracked back directly to a funeral that had taken place in the village of Majola more than a month earlier on 21 March, even before the national lockdown started. This funeral, along with two others in the city of Port Elizabeth, were said to have accounted for 200 COVID-19 cases in the Eastern Cape – about a quarter of the provincial total at the time.[25] The media narrative around the reporting of the outbreak in Port St Johns also pointed the finger at rural residents, who were portrayed as irredeemably selfish. 'Villagers — including some of those who are infected — do not seem to care', reported the region's *Daily Dispatch* newspaper. 'The chaotic situation in Machibini village, where there is virtually no policing or army boots on the ground, is threatening to realise the health authorities' worst nightmare about a virus explosion in the province's rural areas'.[26] In response to the concerns raised around the spread of the virus from the funeral in the Port St Johns area, the AmaMpondomise Kingdom under King Zwelozuko Matiwane decided to suspend all gatherings, including funerals and night vigils in the villages under its sway.[27] Clarifying the decision,

the AmaMpondomise spokesperson, Nkosi Bakhanyisele Ranuga, said the old tradition of *ukuqhusheka* (secret burials) in which the body was taken straight to the graveyard accompanied by no more than 10 family members would be reinstituted.

As the months passed by, and the COVID-19 crisis intensified in the Eastern Cape, the government restrictions on funerals tightened even further with instructions to shorten the period between death and burial, new cuts to the number of mourners that could attend, and measures insisting that all bodies be tested for COVID-19. The most controversial new measures that were enforced by the funeral parlours, partly for the safety of their own workers, was the placement of dead bodies in triple body bags to avoid contagion and the burial of bodies without allowing the family to view them. This created further anxiety and confusion in rural areas. Some older men and women said that they could not recall a time when the state had wanted to dictate how families performed their customs. They said that the state regulations made it extremely difficult to bury the dead in culturally appropriate ways and to ensure safe passage for their loved ones to the afterlife.[28]

Case studies collected in communities in the former Transkei revealed that restricted access to viewing and interaction with the corpse became a major source of anxiety.[29] The regulations stipulated that the bodies of those who had died from COVID-19 should not be accessible at funerals, especially not inside the house, and should, ideally, be wrapped and buried in solid plastic, even if placed in a coffin. In the case of a large funeral held in June 2020 in Kwa-Nikhwe village in Bizana, the body arrived on the morning of the funeral. The funeral service and rituals took place in the tent (without the body present) and the funeral parlour took the body straight to the gravesite, where it was buried before the funeral guests could bid their final farewells.[30] Many mourners complained about this. The attendees said the funeral parlour had no right to behave as it had but the undertakers said they would have lost their licence if they had broken the law. A similar incident occurred at Maya Location in Qamata, Chris Hani district: The passengers of two Quantum taxis from Cape Town arrived at the funeral to view the body but were told that the funeral parlour had already taken it straight to the gravesite.[31]

During lockdown, when the consumption of alcohol was prohibited, local police raided a number of funerals to overturn drums of *mqomboti* (traditional beer). The sharing of beer and food is critical to the communal ethos of *ubuntu* at funerals. Beer is also needed to reward the gravediggers, whose spades and picks are symbolically washed in 'soothing' traditional beer. In other cases, authorities attempted to shorten funerals to prevent people from lingering and communing further. In June, at a funeral at Bhongweni village in Tsolo in uMhlontlo local municipality, the body arrived from Johannesburg at 4am. In the dark, the family welcomed neighbours to view the body. The next day, 50 people attended the funeral as stipulated under the COVID-19 restrictions. Fearing prosecution, they shortened the funeral to under two hours. The mother said that only two people had spoken at the funeral. She cut it short because she feared that she would go to jail if they had broken the law. Later, she spoke of regretting the decision because the funeral had felt 'incomplete'.[32]

The wrapping of bodies for delivery in three layers of plastic by funeral parlour staff and the depositing of bodies directly in graves, both of which had become common practices by the end of June 2020, created enormous anxiety among the local rural population. In Zixhoseni location,

one woman explained: 'As Xhosa people, we bury our family members in a way that they can come and visit us after death at our homes, and to do this they need to free, not wrapped in plastic.'[33] Another mourner said: 'I can say that our normal way of doing things are disturbed by these COVID rules, because during funerals it is not our culture to wrap people in plastic.'[34] A local community leader added: 'I can say that it is affecting people emotionally because family expect to be able to communicate with the body at the home, and in other ways before they are buried, but this is not possible through plastic.'[35] Another mourner said that wrapping bodies in plastic caused the spirit of the dead person to become 'overheated', creating misfortune and chaos.[36] One ward councillor pointed out that the triple plastic covering made it difficult for people to determine who was in the bag, and that this had led to the wrong corpse being buried in more than one case. He quoted a well-known case in which the wrong body was sent from Cape Town to Cofimvaba for burial, while the Cofimvaba body ended up in KwaZulu-Natal.[37] Local residents said that such mistakes were being made because many nurses, doctors and government bureaucrats were on strike and there were 'no longer qualified people to register the dead'.[38] In a number of instances, communities chased funeral parlour vehicles away from local homesteads because of the alien, unacceptable state in which the bodies were delivered, all wrapped in plastic.

The attitudes of rural residents to the actions of the state in implementing the local down regulations was summed up in the frequent use of the metaphor of the gate closing (*ukuvala isango*) on rural communities. Given the instructions to traditional leaders to enforce the ban on customary practices, they were reluctant to hold meeting and share the new government rules because they knew they would be unpopular. The general sense of alienation and exclusion was expressed in the following statement by a rural resident in May 2020:

> During funeral gatherings, COVID virus is [seen to be] caused by our customs, because the state is at war with us and our customs. We were chased by the police, together with the people who are supposed to govern us, and we had to run in confusion; the way these regulations are expressed and the law enforcement that accompanies them against funerals and customs is as if this was all caused by us.[39]

As a result, secrecy, fear and rumour dominated the rural landscape and people tired of coming to terms with the pandemic at the local level with little information being provided in a format that would allow them to appreciate why some of the rules were imposed. This situation was compounded when local hospitals and clinics started to close across the region. Conditions at the Livingstone Hospital in Nelson Mandela Bay seemed to symbolise the deep-rooted and insurmountable challenges face by the Eastern Cape health care sector, which deepening the popular perception the gate was 'closing', especially in rural areas.

Livingstone Hospital: The Eye of the Storm

In her 2014 book, *Biomedicine in an Unstable Place,* Alice Street argues that public hospitals have long served as sites for imagining the state and, beyond that, modernity too.[40] The collapse of the hospitals of a city, region or state, she argues, is always seen a critical indicator of the developmental capacity and resilience of the place. She argues that in Indonesia, and especially in the country's more remote rural areas, the designation of regions as unstable, uncertain and under-developed is often simply 'read' off the conditions at the local hospitals, which are generally deemed to be sub-standard, chaotic and disorderly in terms of the dominant Western biomedical ideal of a modern hospital.[41] In the context of South Africa and the COVID pandemic, the Livingstone Hospital in the Eastern Cape city of Port Elizabeth became that place, defining the global view of the country and the management of the pandemic. It started in July 2020, when the hospital failed a safety inspection as the first wave of infection rates skyrocketed across the country and the hospitals were under scrutiny. Livingstone Hospital was already on the radar of journalists and the media because of Minister Mkize's visit to the facility in April, where he acknowledged provincial challenges but vowed to plug gaps by transferring specialist staff in the national system to the province and the hospital.

On early July 2020, Estelle Ellis of the *Daily Maverick* broke the story that the hospital had failed a safety inspection and that: 'patients, visitors and employees at Port Elizabeth's Livingstone Hospital were met with the horrifying sight of rats licking at water the colour of blood pouring from a blocked drain'.[42] The Department of Health officials disputed the claims saying that 'an unknown person had put beetroot peels down the drain, causing the water to turn red'.[43] The report found that sanitary condition of the hospital was simply appalling with piles of rubbish and medical waste lining the passages, while patients slept wherever they could find space inside or outside the wards. Ellis claimed that the causality unit had sent out messages in mid-June saying that conditions at the hospital were 'dangerously unsanitary' and the none of the appointments promised when the Minister visited had been made.[44] Staff at the hospital had also embarked on a go-slow strike after a disagreement over overtime in June. The hospital was described as rudderless, toxic and dangerous institution without proper protocols, PPE or protection from infection for staff or patients. Ntiski Mpulo from the Eastern Cape Health Crisis Committee said that the conditions at Livingstone Hospital had 'deteriorated catastrophically in recent times'. The reports on Livingstone attracted the international media with a week-long visit from the BBC and reports on Sky News from the hospital and cemeteries in the windy city. Andrew Harding of the BBC found doctors and nurses at Livingstone Hospital to be exhausted and overwhelmed with COVID patients. They added that patients were sleeping on newspaper on the floor and that the hospital was out of oxygen and had a severe shortage of ambulances and ventilators. The journalist described scenes from the hospital as 'like a war zone'.[45]

The images of the hospital in crisis were beamed across the globe by the BBC and Sky News in a series of special reports on the COVID-19 crisis in South Africa. The unwashed corridors and blood-stained wards without staff revealed the extreme conditions prevalent in the Eastern Cape, the weakest link in a national health care system that was buckling under severe strain.[46] Livingstone Hospital came to represent the state of province and the country. Dr Black, head

of the infectious diseases unit at the hospital, reported that the institution was down to 30 per cent of its staff complement, and that there was a huge amount of fear, as well as emotional and mental fatigue at the facility. Services are 'starting to crumble under the strain', he said, because 'COVID-19 has opened up the cracks in the system – it has created a lot of conflict'. At nearby Dora Nginza Hospital, which had a large maternity ward, Harding reported that mothers and babies were dying. He quotes nurses saying that there were several mother and infant deaths every week, which had been unheard-of before COVID-19. Harding said that public sector unions had shut down hospital after hospital in the province and had refused to budge until their demands were met, leaving patients without care. The public did not support the strike action, he said, but the nurses' unions and other professional bodies said that they should only return when it was safe. The piece ends by suggesting that the horror on display at the two hospitals was not a flash-in-the-pan but emblematic of a provincial health system and service which had been in a state of retreat in the Eastern Cape for the past 10 years. Harding viewed the dirty floors, linen, wards and conditions at the hospitals as indicative of a larger national problem – a sign of the state of the nation – just as Alice Street would have predicted he might.

The failure of Livingstone Hospital and its doctors and nurses to hold their ground in the face of the COVID-19 crisis provided a lasting image for the failure of the province to manage the escalating pandemic, as it recorded more than 2 000 new infections a day by early July 2020. However, the problem with using the hospital to express the crisis in the province was that it confined the gaze of the media and the world to conditions in the city, when the vast majority of those living in the region were in rural areas and served by rural clinics. The threat to staff and patients of unsanitary conditions and the lack of PPE, represented at Livingstone by rats licking blood at a drain, became the single most important issue that brought the health care system and the government to a standstill. Sterile environments were required in all government institutions.

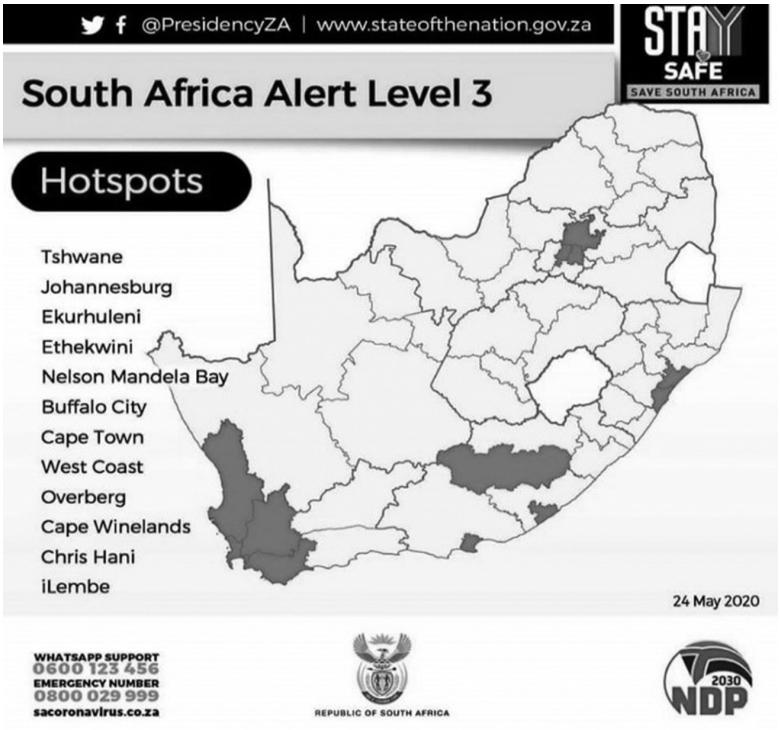
The Closure of Rural Health Facilities

The state's failure to 'deep clean' infected public spaces came to the fore for the first time in the province in early May 2020, when Zwide Clinic in Port Elizabeth closed down because one nurse had died and 11 others had tested positive for COVID-19.[47] The metro moved to clean the facility but had neither the PPE equipment nor the willing staff to get the job done properly. Only the pharmacy was deep cleaned. In response, the nurses complained to their union, who supported them in their refusal to return to an unsafe work environment. The Zwide Clinic crisis proved to be the tip of the iceberg as public sector facilities closed like dominoes across the province because of reported infections. By mid-May, more than 10 police stations, mainly in the western part of the province, had been shuttered due to outbreaks and public safety concerns. Meanwhile, Home Affairs offices were also closed in the large metros and urban centres, together with several smaller rural hospitals in places such as Centane and Komga and clinics.[48]

Members of public sector unions, including the Police and Prisons Civil Rights Union (POPCRU), stood firm by refusing to return to work until their stations had been professionally,

systematically cleaned. Improper or partial cleaning was unacceptable. The absence of trained staff, appropriate equipment and professional systems to conduct proper deep cleaning and to return buildings to functionality led to many key parts of the health system and the government being shut down. The closures were also partly a consequence of more rigorous testing for the virus among public servants, which revealed a significant number of cases. Notwithstanding the reasons for the shutdowns, public servants were criticised for not being available to assist those in need. People noted that the police were operating roadblocks without masks or protective gear and yet there seemed to be a general lack of commitment among public servants to re-open clinics, police stations and services to the public.

In the second half of May 2020, it emerged that infections were starting to spike in the rural district municipalities of OR Tambo and Chris Hani. The image below of the national hotspots on 24 May 2020 illustrates the emergence of Chris Hani, soon to be followed by OR Tambo, as rural flash points for the rapid spread of the pandemic in South Africa. Deep migration tracks in and out of these areas from Gauteng and Durban in the case of OR Tambo; and Cape Town, Port Elizabeth and East London in the case of Chris Hani, made them the first rural hotspots in South Africa and among the most vulnerable areas in the country. At this time, the situation at hospitals in East London and Mthatha received increasing attention in the national media, especially in relation to their periodic closure and the shortage of PPE for the staff there. Nurses claimed that these hospitals were still using the old green gowns, which were unsafe and should



be replaced with appropriate PPE. Frere Hospital in East London and Mthatha Hospital both closed at a time when more and more people were seeking help.

By the end of July, the Eastern Cape had over 75 000 confirmed cases of COVID-19, more than 1 500 official COVID-19 deaths (and perhaps at least three times that amount unofficially), and 58 000 recoveries.[49] To compound matters, 3 500 health workers had tested positive for the virus and 56 had lost their lives. At Livingstone, one doctor summed it up as follows: 'we have 1 200 beds for COVID-19 patients, but only 200 are oxygenated, and there are currently enough staff to serve 30 beds'.[50] Another doctor stated that it was an impossible situation because: 'You can't administer anything through them [the provincial health department] because it will go missing. It all boils down to the fact that the department is dysfunctional beyond belief and has no money.'[51]

It was this recognition that led Mkhize to intervene again in mid-July, seeking to create a new 'turn-around strategy' with the help of his own adviser, Dr Sibongile Zungu, who was sent to join the Eastern Cape COVID-19 project management team, and with the support of the Eastern Cape Premier, Oscar Mabuyane. The premier supported the strategy with a new commitment of R2.5 billion from the provincial budget. He said that R840 million of this would go towards building field hospitals around the province; another R480 million would go to addressing backlogs in PPE; R173 million would fund the purchase of ventilators; R17 million would be spent on increasing the capacity of nursing staff; and R12 million would fund Cuban doctors brought into local hospitals to block the gaps.[52] It was also announced at this time that 75 doctors from the National Defence Force would be relocated to the province.

Throughout this period, evidence of the poor conditions at rural hospitals increasingly came to the fore, including in the media. In rural Centane, doctors and nurses were so deprived of drugs and PPE that they walked out of the hospital in early June, leaving patients in their beds. They told the media that they would no longer risk their lives day in and day out because of the government's failure to implement PPE and the accepted standard operating procedures at their hospital. More than 100 people working at the hospital allegedly downed tools. They said that they would not return until they had access to PPE and the facility was disinfected, noting that one hospital clerk had already died and several others on the staff were now critically ill. At the Frontier Provincial Hospital in Komani, nurses also went on strike because of the absence of protective gear and their inability to control mentally ill patients, transferred from a nearby psychiatric hospital, who wandered the corridors and refused to follow rules. The action was taken after 56 nurses at the hospital had tested positive for COVID-19. It was supported by the Democratic Nurses Organisation of South Africa (DENOSA), which called for the resignation of the hospital's CEO for allowing the facility to be overrun by COVID-19. These developments provoked rural nurses in clinics to follow suit and shut facilities until they were cleaned and staff could be tested.[53]

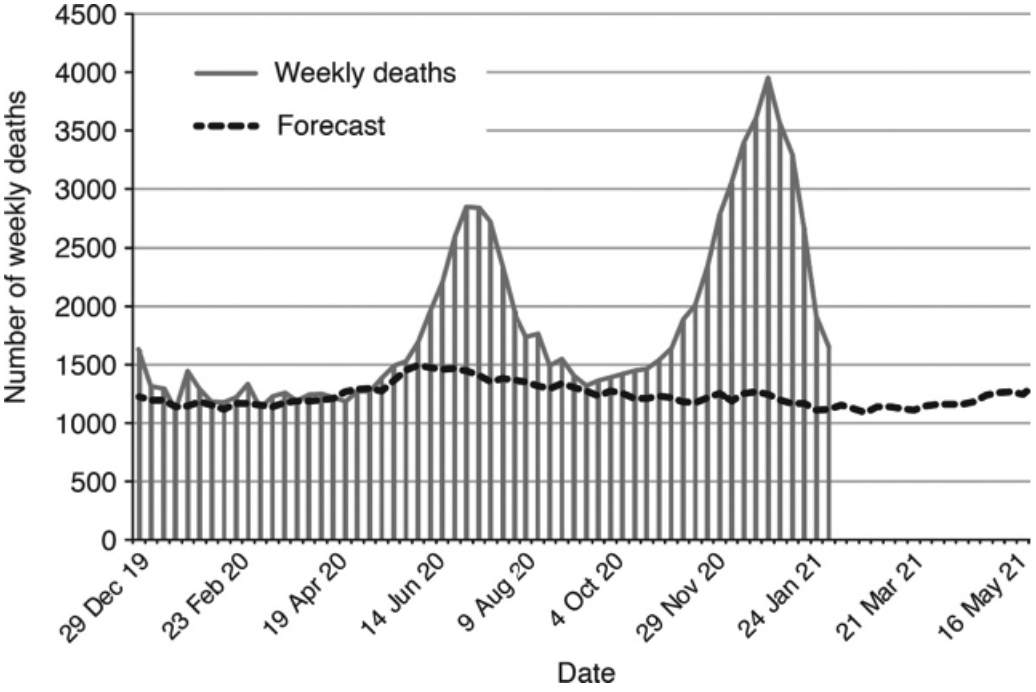
At Komga Hospital, the public complained that families had been left to care for themselves after the nurses there also walked out. It was also reported that the hospital was no longer processing the paperwork required to release the bodies of patients who had died. The family of Anele Mxhosana was among those who petitioned the health department to produce the appropriate paperwork.[54] The closure of rural hospitals and clinics created panic and anger in

rural areas. This study found that rural villagers were bitterly disappointed at the inability of the formal health system to address their needs. Many said that they had relied on traditional healers and local herbal remedies when they were unable to source help at their local clinics and hospitals. In other reports received from the different districts in the former Transkei, rural families complained about the failure of nurses to be ready or sympathetic, saying they lacked the capacity to provide essential services when rural 'people needed them most'. Statements, like the following, were common: 'The nurses here only seem to care for themselves. You will not see them at the clinics. They are hiding away. The clinics are closed because they are scared'. Others stated that the clinics did not seem to have any dedicated information, or strategy to deal with COVID-19, and they just referred people to the urban hospitals, which they could see were failing. Some people said that local people from prominent families were talking about driving the sick to Durban, Cape Town or Johannesburg because of the lack of services available in the province. There is no doubt some truth to the statements that some nurses were not at their stations in rural clinics because of fear and uncertainty about the pandemic, and their perceived vulnerability to infection. However, closer investigation reveals that the criticism of rural nurses and clinic staff generally has been somewhat unwarranted. The fact of the matter is that there was considerable confusion throughout April, May, June and July about the support that the rural health sector would be able to provide.

The rural nurses interviewed as part of this research stated that they had received no training whatsoever on how to deal with COVID-19 cases. They stated that the health department had notified the clinics that training would be provided, but it never happened, presumably because the provincial department was thrown into crisis with the shock of the pandemic. The nurses said that they were referring patients to urban and some rural hospitals because they did not feel trained to deal with them. It was also reported that the national Department of Health had informed regional structures that specially trained COVID-19 nurses would be deployed to the rural parts of the Eastern Cape to assist with the management of the pandemic. This measure was not well-communicated and was alleged interpreted in some areas as a statement that the existing nursing staff would be replaced by new nurses and would lose their jobs because they had not been trained to deal with COVID-19. Perhaps in response to these feared job losses, stories began to circulated that the COVID-19 nurses who had been promised were actually carriers of virus and rural people should be careful not to interact with them because they would be infected if they did.

Meanwhile, a lack of medicines to dispense at rural clinics added to the perception that these institutions were ineffective at this time of need. Many informants said that they did not even attempt to go to the clinic, first, because they feared it would be dangerous space for infection and, second, because they doubted the ability of clinics to be of much help. Our fieldwork revealed there was little resistance to embracing Western biomedical treatments in the rural areas. In fact, the interviewees were keen to access medication and support from the clinics, but they said that nurses and clinics were just not in a good position to respond to their needs. When they did make contact, most said that they were simply referred to the city hospitals – which were generally closed.

Chart 1: Excess death in the Eastern Cape during the first and second wave[55]



The full impact of the pandemic in the Eastern Cape over the traumatic first and second wave only became visible when the Medical Research Council (MRC) released data on excess death. This data is mapped in Chart 1. The MRC reported that a total of 33 072 people died between May 2020 and 13 March 2021 in the Eastern Cape. This puts the excess death rate at 502/100 000 of the population — double the national excess death rate. In comparison to the World Health Organisation's COVID-19 data, these mortality rates are among the highest in the world and significantly higher than those of Italy (175/100 000), the United States (166/100 000), Spain (157/100 000) and Brazil (142/100 000). Eastern Cape health department spokesperson Sizwe Kupelo said the analysis of COVID-19 deaths by the department's Dr Nokuzola Ntlangula found that 40 per cent of patients died either in hospitals' casualty wards or within 48 hours after admission.[56] Perhaps most telling was the extent to which the rural areas had bore the brunt of the excess death. The award-winning health journalist, Estelle Ellis explained that: 'the province has a case fatality rate of 6% at present, meaning that 6% of those diagnosed with COVID-19 died. The Chris Hani district, including districts in the former homelands of the Ciskei and Transkei, and the area around Komani (Queenstown), Cradock and Middelburg has the province's highest case fatality rate at 7.9%'.[57] The fear and panic that dominated the rural Eastern Cape in 2020 and the early months of 2021was grounded in these harrowing statistic.

Conclusion

By contrast to the engaged response of communities and health care professionals, especially those in NGOs and the World Health Organisation, during the Ebola epidemic in West Africa in the early 2010s, the outbreak of the COVID pandemic in rural South Africa has seen rural communities recoil in fear as the state specifically targeted customary practices and rural funerals in the former homelands as special sites of infection. This led some community members to claim that it appeared as if custom itself was the cause of the deadly virus. The repressive campaigned launched by the state with the support of traditional leaders during April and May 2020 enforced harsh restrictions at funerals without an effective communication with households and communities. This instilled panic and concern that the dead would not be able to navigate a peaceful passage to the afterlife, especially if they were buried without dignity and bundled in graves in plastic bags from which their spirits could not escape.[58]

The anxieties families felt were expressed in dreams of loved ones sweating and writhing in plastic captivity, while others felt that the rigidities of the state rules and the limits on attendance, caused people to fear these events rather than embrace them. They wondered how the death of an urban gangster and a distinguished village elder could be considered similar events. How could they bury their most valued elderly community members with only a handful of mourners present and what would it mean, in the long term, if key elements of the burial rites were omitted, like the night vigil with close kin, or the slaughtering of a sacrificial beast for the ancestors or the brewing of beer, was removed from the ritual programme. How could people buried under these circumstances ever rest in peace. Families argued that while small, modest funerals concluded in two hours with one or two speakers might be appropriate for the youth, they were completely inappropriate for more mature members of the community whose standing and *isidima* (dignity) demanded greater acknowledgement.[59] There was pervasive feeling that the family business of death was dishonoured, leaving families in a suspended state of emotional, spiritual and material insecurity. They yearned for contextually appropriate forms of 'people's science' where the threat of the disease and the requirements of their culture could be better balanced and accommodated. They also resented the absence of senior traditional leaders and prominent bureaucrats from funerals as they feared for their lives under lockdown conditions.

At the same time, the rural health system, and especially the clinics and rural hospitals, on which rural folk relied heavily collapsed like a pack of cards in a province with insufficient ICU facilities, appropriately trained medical staff or enough the protective gear and deep cleaning equipment to keep hospitals and clinics open. There are plenty of stories of the heroic and committed actions by individual doctors and nurses to overcome these difficulties,[60] but the net effect of the closures compounded fear and insecurity in a context where many had come to depend on their local clinics as medicine, care, information, and communication. Protocols and engagements established and refined during a two-decade long struggle with HIV/AIDS had created dependency on these facilities. The use of the metaphor *ukuvala isango* (closing the gate) thus referred not only to the vacuum created by shutting down customary practices and clinics, but also expressed the sense of abandonment families felt in their time of need. Two out

of three rural households in the Eastern Cape, for example, relied on the state monthly grants for survival. State dependency looms large in rural life in South Africa, and during the first year of COVID crisis, rural social relations did not shift, as they had in West Africa, to improvisation and new forms of 'people's science' and community practice based on informed learning, community education, mitigation, and prevention. The dominant sentiment was, as suggested above, was one of betrayal, neglect and victimisation.

By mid-2021, a full year and a half into the COVID crisis, the national government's response to the pandemic changed course as vaccines became readily available and were then rolled out to every corner of the country, including in rural areas in the Eastern Cape. Thousands of new health workers were employed to help the health department meet the provincial target of vaccinating 4 million people before the end the year. As rural communities cast a jaundiced eye across their villages to the facilities that had forsaken them, they experienced a deep sense of reservation, ambivalence and mixed emotion. The region had been ravaged by the virus, registering per capita death rates far in excess of many countries in the West, the USA and even Brazil. There was thus a strong desire to vaccinate in the shadow of so much death and devastation. They were also quick to learn that their access to government services and jobs in the cities in future, including access to the special COVID grants, would require proof of vaccination.[61] Many stayed away during the November local government elections, where voter turnout hit an all-time low in rural areas in the Eastern Cape to register their protest. But at the same time, with the Omicron variant on the horizon in late 2021, many also figured that compliance might be better than resistance.

There has been much to commend the new engaged approach of the Eastern Cape Department of Health, especially since the appointment of Dr Rolene Wagner as Director General in August 2021. The new departmental campaign has specifically targeted rural outreach, partnership and community engagement in their vaccine rollout strategy and programme. The new people are people friendly and the focused strategy has delivered positive results with the province having reached 40 per cent vaccination rate by beginning of 2022. There can be no doubt that the gate has re-opened, but it is also clear, from the dearth of socially embedded community preventive health care forums and strategies in the region, that a democratic rural health care system and the emergence of a new 'people's science' is still some way off.[62]

Notes and References

1. This article was submitted in November 2020 and has been revised in January 2022. The article is based on ethically approved, research undertaken for the Eastern Cape Socio-Economic Consultative Council (ECSECC) in 2020 and then extended with HSRC funding into the second wave of infection in December 2020 and January 2021. Bank and Sharpley were also supported in the work by selected WSU staff and post-graduate students locked down in rural villages in the eastern half of the Eastern Cape in 2020. We acknowledge financial support from ECSECC and the HSRC, as well as the critical inputs of our WSU colleagues. The municipalities covered were Intsika Yethu, Engcobo, Umhlontlo, Nyandeni, King Sabata Dalindyebo, Umzimvubu, Bizana and Ingquza. The Walter Sisulu University fieldwork team included Vuyiswa Taleni, Mandlakazi Tshunungwa, Puleng Morori, Buleka Shumane, Athi Phiwane, Zipho Xego, Siyasanga Fayini, Balindi Mayosi, Phelisa Ellen Nombila and Singa Siyasanga from the Department of the Humanities, Social Sciences and Law. The authors of the article acknowledge and thank the fieldworkers for the role they played in gathering information under lockdown conditions. The views and analysis provided in the paper are those of the authors rather than the institutions that funded the research.

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