PSIA – Paris School of International Affairs

Master in International Development

MOVING AT THE SPEED OF TRUST:

A Comparative Analysis of Grassroots and Community-based Covid-19 Responses in South Africa and India

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ABSTRACT

2020 and 2021 saw the widespread use of national lockdowns and stay at home measures to prevent the spread of the Covid-19 virus. As police forces were deployed to enforce the rules and people fell into financial hardship, marginalized populations in the Global South were left behind in substandard living conditions with limited access to food and clean water. The Covid-19 pandemic provides an opportunity to reconsider the dominant narratives of securitization and vertical, top-down responses to a global health crisis. While global attention remains on multilateral and state-level actors, often based in the North, less is known about the impacts of grassroots and community-based responses on ensuring health and well-being. In the Global South, civil society responders, citizen volunteers, and local governance played an outsize role in providing food, water, shelter, and sanitation materials to those in need. In doing so, they have expanded the narrative of pandemic response to include a comprehensive understanding of health and well-being, reframing global health from security to human rights.

The large-scale mobilization of grassroots and community actors also holds implications for the role of public participation in public health and global health, calling for a more participatory and transparent health governance. Through a comparative case study of bottom-up interventions in South Africa and India, I observe the realities of on-the-ground Covid-19 relief work, and I reflect on the gap between top-down and bottom-up actors in global health and how to bridge it. I argue that the power and legitimacy of grassroots and community health has been highlighted by their role in pandemic response, opening a window of opportunity to re-politicize socioeconomic rights, restore a comprehensive rights-based framework to health, and promote public engagement in health systems.

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CHAPTER 1: INTRODUCTION

"We need to start by situating the epidemic in its political, economic and social context. How we understand Covid-19 should shape how we organise to respond to it. We cannot respond to Covid-19 as if it is an ahistorical [phenomenon]; completely unexpected; disconnected from the other crises that are going on in the world."

– Mark Heywood, Notes prepared for UKZN, Centre for Civil Society Webinar Series, June 10, 2020.

In an April 2020 episode of the critically acclaimed *New York Times* podcast *Still Processing*, hosts Wesley Morris and Jenna Wortham discussed the parallels of the SARS-COV-2 (Covid-19) virus sweeping the world and the HIV/AIDS pandemic that threatened the human population in the previous century. They highlighted a central theme present in both pandemic events: inequality in the way the same virus affects different individuals and different communities. In particular, the episode focused on the way the HIV/AIDS pandemic disproportionately affected the queer community and played against a landscape of homophobic and classist structures of power and visibility, similar to how the Covid-19

virus disproportionately infected and killed people of color in the United States due to preexisting discriminatory structures embedded in the health system. In an apt reflection on the lessons learned from both pandemics, Wortham states, voice thick with emotion, that she hopes that any return to normal from the adversities of Covid-19 is a "slightly tweaked normal" in which "we understand that health is not a given, and that some people are always ill and always unwell because of the societal conditions under which they live" (Morris et al., 2020). That statement has guided my interpretation of the underpinning social inequality throughout the pandemic's trajectory – infections, lockdowns, restrictions, job loss, triage in hospitals, and the global Covid-19 vaccination campaign.

The Covid-19 pandemic from 2020 to the present day has been a litmus test for how well the system of global health and public health has developed around the world. Despite strides in grassroots and community health projects in recent decades towards health equity, the response to the Covid-19 outbreak in 2020 has shown how quickly public health reverts to top-down, command-and-control, nationalized strategies away from inclusiveness and public engagement in the face of disaster. The narrative of national security and warfare quickly invaded political rhetoric. Through the logic of securitization, lockdowns and curfews were soon put in place to limit citizens' movement. Police and national guards were deployed to enforce these measures and to maintain order. Countries squabbled with neighboring countries over supplies, medical equipment, and vaccines. Throughout the geopolitical chaos, national governance and international organizations seem to have abandoned the lessons learned on the value of a rights-based, collaborative, cooperative, and grassroots approach to global health. If Covid-19 is a test, then the global health system, with its illusion of transformative progress and solidarity, is failing.

These top-down, command-and-control strategies to respond to the Covid-19 pandemic in 2020 have subjected their populations to physical and mental harm, possibly outweighing their benefits. Amnesty International released a report on police crackdowns during the Covid-19 pandemic in 2020 that documents cases of police brutality in 60 countries, ranging from the use of tear gas to suppress protests to police killings while enforcing curfew. Meanwhile, little government policy and media attention has been paid to civil society initiatives that have occurred in response to the emergency, particularly at the grassroots and community health level. Paradoxically, civil society organizations have

taken large cuts in donor funding and government resources, even as grassroots non-profits have the most on-the-ground knowledge to serve as frontline humanitarian responders to the most vulnerable populations.

The term "grassroots" can be as difficult to define as the concept of "global health," and the two do not necessarily stand in opposition to each other. According to Anheier et al. (2005), who have catalogued and defined a dictionary of terms used in the non-profit sector, a grassroot association is "a self-organized group of individuals pursuing common interests through a volunteer-based, non-profit organization," often "vehicles through which disadvantaged people organize themselves to improve the social, cultural and economic well-being of their families, communities and societies" (p. 117). In my case studies, I will describe both grassroots organizations and community-based organizations, and show how the boundaries between grassroot, community-based, social movement, and civil society, though important, can be blurred or merged. For the purposes of my study, the grassroots and community-based organizations that I research are those that stand in contrast to multilateral institutions of global health governance and large private philanthropic foundations that dominate the global health agenda, although they do so in varying degrees of association and non-association with these powerhouses.

This thesis seeks to explore underlying unwellness during the Covid-19 pandemic from 2020 until the present day through the examination of response measures at the grassroots and community levels. Although much global health discourse has underlined the importance of social determinants of illness, global health continues to narrowly intervene on specific health issues often related to specific diseases, rather than addressing persistent issues considered tangential to health. Indeed, whereas I began this research endeavor hoping to examine clinical health at the community level, much of the focus of my research project shifted towards persistent problems that were present before the pandemic and merely exacerbated by the pandemic situation and national lockdowns, such as food security. Between 720 and 811 million people in the world went hungry in 2020, and an estimated additional 118 million people faced hunger in 2020 as opposed to 2019 (World Bank, 2021). Yet prior to the pandemic, an estimated 2 billion people, or 25.9% of the world's population, already "experienced hunger or did not have regular access to nutritious and sufficient food" (FAO et al., 2020). If feeding the hungry and housing the

poor is often framed as a humanitarian or charity mission, the Covid-19 pandemic serves as a wake-up call to the precariousness of food security, housing security, job security, and access to health around the world and the enormous ripple effects one shock can have on fragile states of survival and well-being. It asks if a fragile state of survival can be considered health or well-being in any context.

Approaching these topics through the lens of on-the-ground emergency response initiatives came out of my reflections on inclusivity and power-sharing in health governance. It was not too long ago that HIV/AIDS activists marched on the streets of South Africa demanding access to antiretrovirals and an end to AIDS denialism, a show of strength from the marginalized and the stigmatized, which challenged neoliberal and capitalistic justifications for upholding pharmaceutical patent laws over the interests of public health. Decades later, the same uncomfortable inequalities in wealth and power are reproduced in the form of vaccination gaps between the Global North and the Global South and the debate on vaccine patents. Yet, as will be shown in my discussion on South Africa and India, efforts are being made to address the fundamental inequalities that have aggravated the Covid-19 situation. Efforts such as the People's Coalition on Covid-19 in South Africa aim to address the root problems of food insecurity and inadequate standards of living by challenging the systems that keep them in place. The pandemic provides the global health community with the opportunity to reconsider the way systems are normally run, and it provides a window of opportunity to listen to people on the ground when they deconstruct, challenge, criticize, and proffer alternatives to the old normal.

As the pandemic persists into 2022, it is important for development and global health policymakers, academics, and practitioners alike to take stock of the lessons learned from the initial waves of the Covid-19 pandemic. I was struck by how many of the interview participants I encountered who said that they appreciated the opportunity to reflect on the meaning and deeper implications of their work, as they had not done so yet. One such interviewee from Cape Town, South Africa noted that these kinds of deeper reflections were necessary to improve on our current models of pandemic preparedness, identify what went wrong, and build sustainable solutions to the problems people faced during these so-called unprecedented times.

1.1 Research Purpose

This project aims to apply rights-based health and community health frameworks to an alternative model of Covid-19 emergency response in contrast to the mainstream statewide command-and-control procedures witnessed in 2020. Comparing case studies of South Africa and India, it will mostly draw from grassroots and local innovations in the Global South. However, innovative grassroots health strategies can and should be incorporated in the policies of the Global North, which has suffered greatly in Covid-19 deaths and cases. The purpose of this research is to compare and synthesize pre-existing and current localized approaches to the Covid-19 emergency response as alternatives to a top-down, command-and-control, militarized approach. It will be an examination of how health emergency responses can be more in tune with their beneficiaries, how on-the-ground creativity and willpower in under-resourced areas can be leveraged for a more effective response, and how such emergency responses can be more inclusive, equitable, and nuanced. It also looks to the South for guidance on Covid-19 measures, counter to the dominant protectionist and global security frameworks proposed by the North. Thus, this research project is guided by the following question:

> How can public and global health systems engage grassroots and community-based strategies in the Covid-19 emergency response as an alternative to top-down policies focused on command-and-control measures?

To elucidate the objective of my research, further guiding questions include:

- What lessons learned from past experiences with grassroots public health movements and community health programs should be considered in states' current pandemic response?
- How can health governance systems reorganize to place the public in public health even during crises? What can the Global South teach us about this Western-focused debate?

- What does it mean to be a Global South citizen or grassroots voice in the midst of a global health crisis?

There is both an empirical-descriptive element to my case studies coupled with a normative argument advocating for the support of local responses by resourced institutions. Underlying this thesis will be an appeal to move away from top-down global health in general and to combine it with bottom-up approaches and grassroots expertise. Many global health interventions are driven by leaders in the Global North and international organizations. Since the transition from "international health" to "global health," organizations like the Gates Foundation and the Global Fund have been setting the goals and priorities, funneling millions of dollars to Africa, South Asia, and Latin America and the Caribbean. Arguably, philanthropy-led initiatives have undermined the democratic decision-making principles of the WHO as well as smaller grassroots initiatives founded in the Global South. Furthermore, the uncomfortable legacy of colonial biomedicine in the Global South must be considered when enforcing rules, regulations, and treatments developed in the West in the name of public health. By highlighting the potential of communal responses and grassroots programming, I hope to place decision-making power and autonomy back in the hands of "beneficiaries," so that they become partners and stakeholders rather than voiceless patients of the global health system.

There are two things this thesis will not do. Firstly, while I attempt to construct a grassroots-based alternative, I am not advocating for a complete dismantling of top-down structures and an entirely new model of pandemic governance. I am arguing for a shift in the way we think about who decides, whose decisions matter, and whose voices are given the most resources and power during a public health crisis. I do not intend to romanticize or overstate the value of grassroots involvement and community involvement in public policy, but I am arguing to rebalance the scales of who gains autonomy and control of resources during a pandemic emergency. Secondly, I will not articulate the specificities and nuances of an alternative grassroots model to emergency response, because that would defeat the purpose of my paper. Any crisis response model must fit the local context, and a comparative case study of South Africa and India is not generalizable enough to be entirely applicable to other countries and local contexts. The aim of my thesis is to recognize and describe the innovations and spaces of civic discourse and dissent, to direct

attention to the work already being accomplished at the grassroots, and to demonstrate that the construction of such an alternative model should be a decision ultimately based in the communities that such policies affect.

1.2 METHODOLOGY

In order to explore and analyze grassroots and community health interventions in response to the Covid-19 pandemic, I conducted a comparative case study of two countries: South Africa and India. Case study methods allow the researcher to empirically examine a phenomenon, in this case bottom-up responses to Covid-19, in its real-life context, relying on multiple sources to parse the boundaries between phenomenon and context (Agranoff & Radin, 1991, p. 204). These case studies draw on data gathered through in-depth interviews with local organizations mostly headquartered in major urban sites of their respective countries, such as Cape Town and Mumbai. In the section below, I will detail how I found and selected interviewees out of the myriad of nonprofit organizations and grassroots associations that played a role in the Covid-19 response. These interviews were also supplemented with other case study materials, including websites, social media pages, NGO documents, presentation slides, brochures, pamphlets, promotional videos, documentary videos, reports, and journal articles that I independently found and that were provided to me by the organizations themselves. In each case, I delve into the sociopolitical histories that shaped the public health response, and I compare the grassroots responses to the top-down measures taken by their respective national governments. While the time frame of my research project intends to capture the Covid-19 crisis in its entirety thus far, much of my research lies in the examination of early responses to the first few waves of the pandemic, spanning from early 2020 to mid-2021, when the primary focus of Covid-19 responses shifted to the Covid-19 vaccine rollout. While I touch on the vaccine rollout in my case study discussions, an in-depth examination of the grassroots support for the campaign is beyond the scope of my research project.

1.2.1 Case Studies: Why South Africa and India?

At first glance, choosing two country case studies with such disparate, multi-faceted, and unique societies, each with different historical legacies and relationships with colonialism, renders them very challenging to compare. Certainly, South Africa and India represent two very distinct contexts and social landscapes over which the Covid-19 pandemic played out differently. Many different pairs and groups of countries could likely help me answer my core research question and reach different verdicts on the importance of grassroots and community health responses. However, these two cases were chosen based on a tangible set of criteria, which taken together provide a justification for why the comparison between South Africa and India in particular provides the lens through which we can adjudge the value of bottom-up policies.

Both South Africa and India have legacies of pro-democratic, pro-poor, grassroots-led public health movements that have challenged the mainstream, neoliberal development narrative. In South Africa, popular movements such as Treatment Action Campaign protested the costliness and lack of access to HIV/AIDS treatment, particularly for low-income people living with AIDS in the Global South. In India, formal health system strengthening has aimed to uplift local health workers and primary health and empower panchayats (village governance) to manage and promote health. Although very different in nature, these legacies of contestation and social activism have created a strong civil society presence in both countries, in which a large number of humanitarian organizations, disaster relief and aid organizations, philanthropy foundations, activist groups, formal NGOs, religious NGOs, community interest groups, community kitchens, social enterprises, and more operate in one city or region. This diversity has generated a relatively large amount of research, data, and information about these civil society organizations throughout the pandemic, along with adequate reporting on the Covid-19 situation in both countries. It also allowed me to widen my net when seeking organizations to interview and speak to a diversity of grassroots and civil society responders to widen my perspective on bottom-up activity during the pandemic.

Both South Africa and India exhibit strong leadership in their respective continents as middle-to-high incomes countries with democratic systems of governance, yet they each

continue to be plagued by dysfunction and problems of poverty, corruption, politicization, police brutality, and racial, geographical and caste discrimination. Each struggles with its own deeply unequal society with large numbers living in informal settlements and under poor standards of living. It is through these deeply unequal societies that the least-well off and most marginalized can turn to organizing, activism, and preexisting civil society groups to voice their grievances, fulfil their rights, and seek empowerment. It is such strong legacies of grassroots public health and acute inequality that point towards South Africa and India as cases that will contribute to the discourse, currently dominated by the Global North, on how to put the public back in public health. The localized innovations of highly active grassroots collectives and NGOs deserve as much international attention as the geopolitical maneuvers and top-down pandemic measures of their respective national governments. Most international news sources focused on the stringent lockdowns imposed in both countries, which stranded many marginalized groups such as informal settlers and migrant workers, but which were also initially praised by the international community as strong, swift decision-making. As incredibly diverse societies, South Africa and India struggled to contain the pandemic in various settings – urban, rural, informal – which require different kinds of responses and may have benefitted with a more on-the-ground approach rather than the command-and-control approach taken by lockdowns and policing.

While I did not set out to highlight specific cities or regions in South Africa and India, I often homed in on urban areas, as those were the areas with the most prominent civil society and grassroots response efforts. Cape Town quickly became a focus of my South Africa case study for good reason. It was the starting point for the celebrated Community Action Networks that multiplied across the country, and it hosts many social justice activists and academics who have long decried the abject and unequal social conditions many South Africans face, particularly in shantytowns surrounding major South African cities. Furthermore, the snowball sampling method, discussed below, often linked me to people who operated in the same Cape Town region, or who had been connected through the Community Action Networks in Cape Town. In India, interviewee organizations proved more scattered, but many were based in Mumbai or New Delhi, mirroring a tendency for NGOs and aid organizations to cluster around large cities and

informal settlements. Thus, the setting of the under-resourced urban informal settlement became a key component to my study on grassroots responses to Covid-19, although I did not initially endeavor to focus on it.

As a final practicality, both countries count English among their national languages and contain large swaths of English speakers in their populations, making it easier for me to find and interview English-speaking representatives from various civil society organizations.

1.2.2 Interviews

The interviews that I conducted were semi-structured, open-ended interviews over video and phone call, conducted between June 2021 and December 2021. I interviewed 23 people in total, 12 from South Africa and 11 from India. Most were interviewed individually, although three of the interviews I conducted were with small groups. Of the interviewees, five were academics, all from South Africa, although all were involved in the mutual aid Community Action Networks that are at the heart of my case study on grassroots responses in South Africa. One interviewee worked for the City of Cape Town municipal government under its community development and early childhood development program. The rest of the interviewees were volunteers and representatives of NGOs, humanitarian aid, and mutual aid collectives aiming to mitigate the negative effects of the pandemic. Due to limited resources and the ongoing Covid-19 pandemic, I was unable to visit my case study countries in person and resorted to distanced interviews instead. However, this setback allowed me to utilize interview transcription tools linked to Zoom video call to accurately analyze and quote participants' responses.

The purpose of these interviews was to gain a deeper understanding of the situation, relationships, and dynamics on the ground in the local contexts, so that I could describe and articulate this qualitative data for analysis and comparison. The interviews represent a search for patterns, phenomena, and contradictions across different kinds of community health and grassroots associations responding to the Covid-19 pandemic and navigating humanitarian and public health systems in both countries. They also created a space for interviewees to narrate their stories and experiences and for me as a researcher to put

human faces to organizations and collectives, drawing a thread from the individual to the macro forces each one faces. Thus, my interview questions were loosely arranged into five categories: background on the organization's Covid-19 response activities, successes and challenges, relations with the top-down (governments and donors), reflections on civil society's role, and sustainability beyond the pandemic. With these categories, I attempted to encapsulate both pointed questions for information gathering and more open-ended questions to prompt narrative responses in which the participant interprets their own individual activities in the broader social context (Hollway & Jefferson, 2000).

As I did not have contacts with local organizations in either country, I began my process of selecting organizations to interview by conducting preliminary research examining news articles and academic journals about on-the-ground Covid-19 responses in both countries. From there, I compiled a list of potential interviewee organizations and looked for primary sources created by these organizations, assessing the impact of the organization's activities and their proximity to the grassroots and the communities they served. As I began reaching out to initial organizations, I also asked for referrals and suggestions of whom and what organizations I could speak to next, applying a snowball sampling technique (Cohen & Arieli, 2011). Searching for interview participants was thus an organic process, often based on availability and accessibility. I aimed to speak with a variety of organizations, from larger, established NGOs to small, under-resourced ones, along with mutual aid collectives that came together specifically in response to Covid-19, in order to gain a more holistic view of the ecosystem of aid organizers.

1.2.3 Limitations

There are several limitations to the generalizability of case studies and interviews that apply to this research project. The goal of this research is not to generate generalizable data and conclusions that can be easily applied to other countries or regions of the world. Rather, it is to take two very specific country contexts and delve into the nuances of their bottom-up responses to Covid-19, which each demonstrate in specific ways the importance of recognizing such bottom-up responses. Some lessons learned be applied to the global health community more generally, and some of the insights into countries with a robust

civil society presence could be applicable to other Global South countries. However, the main goal of this research is to examine two specific country cases, and in fact to direct attention to localizing and contextualizing Covid-19 responses, rather than to develop any generalizable model of an effective public health response to a pandemic.

Due to the snowball sampling technique applied to the process of finding interviewees, the selection of interview participants was not completely randomized. While I looked for a diversity of organizations to interview, few were headquartered in rural areas. Furthermore, while I supplemented my case studies with news articles, academic articles, and interviews with people not affiliated with civil society, many NGO representatives may have aimed to highlight the values and benefits of their organizations and of civil society while downplaying the setbacks or critiques. It is true that basing my study on interviews with NGO workers carries a certain bias that can not be overlooked.

It should be noted that my inability to speak the local and indigenous languages present in South Africa and India limited my ability to speak to a representative sample of organizations and grassroots volunteers. Further fieldwork could enhance the understanding of my research topic with more direct access to grassroots volunteers who did not speak English well enough to be interviewed or did not speak English at all. Additionally, all my interview participants needed internet access in order to receive my emailed interview request and in order to conduct the interview itself. While all of the organizations I was interested in had many English-speaking representatives with internet access, this limitation does potentially skew the sample of my interview participants towards those of a higher socioeconomic, class, and educational level. This was likely the case in one rural-based development NGO in India, in which I was only able to speak with one representative, because the other volunteers only spoke the local language. Furthermore, internet access was often a hindrance, as is often the case in the pandemic-induced Zoom era, as many of the participants only had access to weak or unstable internet connections and low broadband. This occasionally impeded my ability to fully comprehend the participant responses to my interview questions, and on more than one occasion, the video froze and the interview was paused for several minutes before we were able to establish a connection again.

1.2.4 Positionality and Reflexivity Statement

Research and researchers do not exist in a vacuum, and an increasing number of experts have weighed in on the importance of positionality and reflexivity in social science knowledge production (Harvey, 2013; Hervik, 1994; Guillemin & Gillam, 2004). Positionality refers to how researchers situate themselves and how or what they know in relation to their research topic, while reflexivity entails "continuous internal introspection over how the researcher's position can affect the whole process and research outcome" (Ntanyoma, 2021, p. 3). Harvey (2013) notes that while reflections on the identities of research subjects are considered as part of the research process, the researcher's identity is rarely examined to the same extent, despite the way researcher's identity determines the entire process of research and the interpretation of findings. Identifying one's positionality and reflecting on it throughout the research process has been recognized as a key piece to conducting ethical social science research.

As a Taiwanese-American graduate student attending a reputable French university, I am very much an outsider in examining topics on South Africa and India, and I have never visited either country. In the discourse on reflexivity, academics have identified several advantages and disadvantages to being both an "outsider" and "insider" to the community under examination (Ntanyoma, 2021, p. 3). While I am not able to share the same "relational intimacy" and "superior understanding of the group's culture" as a native researcher (Bonner & Tolhurst, 2002, p. 13), research participants may be more willing to "deepen discussions" with an outsider who has "limited knowledge of the subject" (Ntanyoma, 2021, p. 3). At the same time, I acknowledge that I often arrived in the research space with a degree of privilege, directly linked to the educational opportunities afforded to me, as I did not face the same dire consequences to my health, food security, and financial stability as several of the research participants and the communities they worked with during the Covid-19 pandemic. My status as a graduate student in a recognized Western institution generated interest among many of the organizations I contacted, and it allowed me to gain access to interviews. While I often felt warmly welcomed by the participants, I also felt that the interviews represented an intrusion on the lives of those whom I could not hope to fully understand or know based on a forty-five minute

conversation. I acknowledge that socio-cultural differences have influenced the way in which this research has been conducted, interpreted, and carried out. My reflections on my role as outsider and researcher have led me to consider decolonizing methods and co-research methods for further research on the topic of grassroots interventions, a reflection that I will elaborate on in my concluding chapter.

1.3 Overview of Chapters

Having clarified my research purpose and methodology in Chapter 1, I will now lay out the structure of my thesis for the chapters to come. In "Chapter 2: Literature Review," I enumerate key global health concepts that frame my research project. I explain the interdisciplinary nature of global health, elucidate the power structures behind contemporary global health governance, and trace the intertwined history of the rights-based health, grassroots health, and Health for All movements. In tracing this history, I discuss the de-politicization of global health and public health interventions in the Global South, and I demonstrate how grassroots movements challenge this hegemonic order. Finally, I elaborate on the debate, occurring most prominently in the North, calling on institutions to put the public back in public health, placing democracy at the center of health decision-making and putting beneficiaries' autonomy at the heart of the health system. I complicate this narrative by reflecting on the contributions of the Global South to this discourse, while acknowledging the challenging component of managing public health during a public health crisis such as the Covid-19 pandemic.

In Chapters 3 and 4: "South Africa" and "India," I lay out my case studies in a descriptive manner and begin analyzing the major components and themes of each case. I begin both cases with a summary of their respective national lockdown trajectories and a critique of their impact on marginalized communities. From there, each case presents a different vision of grassroots and community health in action. In "Chapter 3: South Africa," I profile the immense effort made by civil society, academics, activists, and independent volunteers to form collectives and collaborate on responses to the Covid-19 emergency. I demonstrate how disillusionment with government policies and lackluster official aid drove grassroots solidarity in Cape Town and how the pandemic has presented an

opportunity for these collectives to re-politicize basic rights that directly impact health and well-being, such as the right to food. In "Chapter 4: India," I describe the innovative, holistic approach with which NGOs responded to the crises in their communities, often leveraging pre-existing networks and resources in an efficient and effective manner. The sheer scale and urgency of many Covid-related emergencies, from the migrant worker crisis to the oxygen supply shortage, demanded widespread mobilization and rapid action, allowing civil society organizations to fill in the gaps of the government response. I postulate that India's legacies of decentralized public health allowed places like Kerala, India, celebrated for its robust local government, to better tailor their response to the needs of their communities.

In "Chapter 5: Synthesis: Lessons Learned from South Africa and India," I incorporate the findings from both case studies to draw comparisons and report patterns that I found. I describe the underlying societal conditions and long-standing neglect from the government that worsened the Covid-19 situation for marginalized groups, a phenomenon that was prominent in both countries. I highlight the differences in negotiations between the top-down and bottom-up of both countries and reflect on the importance of collaboration and communication in order to successfully save lives. Through a synthesis of both country cases, I consider four key dimensions to empowering civic responses at the grassroots during an emergency: formal versus informal participatory spaces, networks of solidarity and collaboration, innovation, and public relations. Finally, I demonstrate how the transformation of citizens and civil society into local policymakers and emergency responders constitutes a radical act, one that global health practitioners should take into account going forward. The empowerment of civil society during the pandemic could lead to a re-politicization of basic rights and a reclamation of power too often siphoned away by global health institutions and private foundations.

In "Chapter 6: Conclusion," I call for a reconceptualization of health and well-being in the Global South and a re-politicization of socioeconomic rights. I advocate for a paradigm shift in global health governance under principles of true inclusivity and public participation, away from vaguely virtuous labels of "local" and "community health," especially at the highest levels of decision-making. I revisit the research questions posed in this introductory chapter on putting the public in public health, applying them to the

global health system and posing further questions for continued reflection and consideration. Finally, I return to the idea of co-research and inclusive methodologies in further research, particularly pertinent to the study of grassroots mobilization and social justice in local contexts.

CHAPTER 2: LITERATURE REVIEW

2.1 Global Health Governance: An Interdisciplinary Framework

The construction of a global health framework necessitates melding together many already-existing frameworks across multiple fields. In the Literature Review chapter, I will map out the landscape and intersections of global health and public health governance, rights-based health, crisis management, grassroots organizations, community health, and civic participation. Each of these elements will play key roles to conceptualizing and understanding the links between the Covid-19 global health crisis and the case studies I have chosen in South Africa and India. In fairness, different frameworks used by many different fields (ie. anthropological, ethnographic, biological, epidemiological, public affairs) could be applied to analyzing these cases, yet by utilizing contemporary theories of global health and health development, I hope to draw links between the macro and the micro, the institutional and the practical realities by framing two specific country cases of state-civil society synergies in the larger context of global health and development. Thus, I aim to mine the gap between what has been institutionalized by global health decisionmakers or conceptualized by global health academics and what happens on the ground for strategies to further embed civic participation, local knowledge, and grassroots activism in global health. As it is a public health emergency, the Covid-19 pandemic adds an extra layer of urgency and practicality to my attempt to "put the public back in global

health." The nature of crisis can be a roadblock to a more inclusive and democratic procedure, but it also offers a window of opportunity to reexamine "business as usual" in health decision-making.

To begin understanding the interdisciplinary nature of global health, it is important to adopt the biosocial approach to articulating the causes of disease, as outlined by Hanna and Kleinman in Chapter 2 of Paul Farmer's *Reimagining Global Health*. A biosocial approach of disease claims that "biologic and clinical processes are inflected by society, political economy, history, and culture and are thus best understood as interactions of biological and social processes" (Hanna & Kleinman, 2013, p. 17). Simply stated, place matters, and a disease cannot be understood outside of the context of the geography, both physical and human, upon which it occurs. Notably, the authors state that the biosocial approach "demands the reconciliation and occasional disruption of multiple frames of knowledge," so that disparate fields and their experts do not employ tunnel vision in understanding an illness, but rather synthesize multiple conceptualizations. The biosocial approach searches beyond scientific knowledge and medical expertise for the causes of disease, towards the combined factors of environment, identity, infrastructure, governance, wealth, history, and more in determining one's holistic well-being. Thus, inequities in health directly reflect inequities in social determinants to health and access to resources.

Although the idea of global health appears deceptively simple (i.e., public health but at a global scale), an agreed-upon definition of the concept can be surprisingly elusive. Koplan et al. (2009) set forth a definition of global health reflective of the hope and faith practitioners placed in the rise of global health. They distinguished "global health" from "public health" and "international health," although they recognized that "global health" emerges from and synthesizes both traditions and histories. Therefore, global health is "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide," with an emphasis on "transnational health issues, determinants, and solutions" that involve "many disciplines within and beyond health sciences," synthesizing "population-based prevention with individual-level clinical care" (Koplan et al., 2009). Beaglehole and Bonita (2010), drawing from Koplan et al. (2009), state simply that global health is "collaborative trans-national research and action for promoting health for all." Here again, the authors reinforce the idea of

collaboration – working together to solve issues that transcend boundaries – and "health for all" – the underlying mantra of health equity. A new emphasis on "action" reflects the multitude of global health programs and interventions that persisted through the 1990s and 2000s. Yet the paper does not address action "by whom" and "to whom" nor does it define the specific actions. Instead, similar to the rise of international aid and development, these definitions tend to focus on equitable outcomes rather than equitable processes in improving health around the world.

O'Laughlin (2016) notes the change in development discourse "from poverty to inequality" from the 1990s to the 2010s, so that the field of development is not only concerned with the generation of wealth, but also its control and distribution. Thus, at the level of population health, sociopolitical processes have had as much influence as biological ones. Lakoff (2010) describes global health's deception as a seemingly "shared moral and technical project," though it lacks a truly unified field or purpose (Lakoff, 2010; O'Laughlin, 2016). Instead, he splits the project of global health into two categories: international health security, as represented by health surveillance organizations like the WHO, and humanitarian biomedicine, as represented by international NGOs such as Médecins Sans Frontières (MSF) or Partners in Health (PIH). While the two may seem to operate under two different ethical frameworks and end goals, Lakoff (2010) shows how they are two mutually reinforcing phenomena governed by similar structures of global wealth and power. Levich (2015) demonstrates that pluralist global health institutions (international organizations, courts, humanitarian organizations, social movements) have less influence over global health decision-making than less transparent institutions of global capitalism (World Bank, G7, major foundations, networks of NGOs). Levich labels this limit on democratic participation of healthcare control "global health imperialism." Latour (2009) points out the tendency to overestimate individuals' access to the global sphere when people predominantly live in narrow local corridors.

Throughout my paper, I will refer to an overarching "global health community" to mean the leaders, institutions, foundations, governments, international organizations, NGOs, community-based organizations, and social movements that direct, shape, and govern the health sector. However, within the broader definition of this term, I recognize that wealthy, powerful, and capitalistic institutions, often overrepresented by the Global

North, exercise more power and influence than grassroots movements or civil society organizations from the Global South. "Global health governance" is thus dominated by "a range of inter-governmental organizations, funding agencies, and international bureaucracies" (Robinson, 2018, p. 3). Powerful political institutions (the World Bank, the G7 and the G20), private foundations (Gates Foundation, Rockefeller Foundation), and multinational corporations make decisions every day that have far more pervasive consequences than a community kitchen or a people's health clinic in a Global South country. In my thesis, I challenge this current state of affairs and make the normative argument that such global health governance should include locally based knowledge and decision-making from a plurality of voices. Global governance should be fully inclusive of and accountable to voices from NGOs, civil society, grassroots activists, community members, and citizens to progress towards an interdisciplinary understanding of health in local contexts and ultimately, to fulfilling the original vision of "Health for All."

2.2 The Rise of Rights-based Health, Grassroots Health, and Health For All

This project builds on the foundations of rights-based, grassroots, and community health approaches to development and global health. As my research aims to answer how global health can incorporate bottom-up initiatives, it is important to highlight the frameworks under which community and grassroots programs have been uplifted and diminished by the existing power structures. Human rights law makes the right to health obligatory and offers a framework to advance global health (Robinson, 2018, p. 3). The 1946 preamble to the Constitution of the World Health Organisation (WHO) declared "the enjoyment of the highest attainable standard of health" as a fundamental human right, defining health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," (WHO preamble, 1946) notably applying a holistic and biosocial approach to disease. Shortly after in 1948, the Universal Declaration of Human Rights (UDHR) reinforced a universal "standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services" (UDHR, 1948, Art. 25). In a major turning point for

global health, the 1978 Alma Ata Declaration affirmed the use of local medical knowledge in health interventions, criticized the overrepresentation of elitist Western medicine and top-down interventions, and conceptualized health as an avenue for achieving socioeconomic rights (Basilico et al., 2013, p.79-80), spurring the "Health For All" movement and the universal primary healthcare (PHC) movement.

The foundational documents that defined a "right to health," a "rights-based approach," and "rights-based health" gathered steam in the late 1990s and early 2000s. The rights-based approach to development broadened the narrow focus of civil and political liberties to encompass social, cultural, and economic rights as "indivisible, inter-related and inter-dependent" (Eyben, 2003). The right to health and access to healthcare, as conceptualized in its universal and all-encompassing form, is considered as one of these newer legitimized categories of rights. However, even as the United Nations, governments, and international NGOs began to use the language of rights-based approaches, Gruskin et al. (2010) noted the lack of a definitional consensus for a rights-based approach, resulting in a disconnect between theory and operationalization of a public health rooted in human rights (p. 129). In 2003, the UN attempted to develop a unified definition of the "rights-based approach" through their document titled "Common Understanding on a Human Rights-Based Approach to Development Cooperation." The publication has been criticized as prioritizing consensus over specificity, resulting in a vague definition that leaves room for different interpretations by different agencies (Gruskin et al., 2010, p. 134). However, the WHO uses the Common Understanding to frame the right to health, but it further emphasized the "availability, accessibility, acceptability, and quality of goods and services" as part and parcel of the right to health (Ibid., p. 134-35). Gruskin et al. (2010) also note that the consensus on a rights-based approach to health is clearest in academia, which characterize the concept as "contributing to the fulfillment of human rights, attention to the interdependence of rights necessitating a multi-sectoral response, participation and inclusion of those affected, and consideration of both non-discrimination and accountability" (Ibid., p. 137). My research applies this latter definition of a rights-based health to my evaluation of the Covid-19 pandemic, paying particular attention to the interdependence of rights and the participation and inclusion of those affected.

Following criticisms of some "silver bullet" vertical intervention programs in international health, the push for primary healthcare in the 1970s piqued interest in grassroots implementation of primary health in developing countries. Health practitioners turned to lessons learned from the comprehensive and grassroots nature of public health programs in the Global South, such as the incorporation of local ayurvedic medicine in rural India and the "barefoot doctors" movement in China, a precursor to the community health worker (Basilico et al., 2013, p.76-77). The incorporation of grassroots voices and grassroots knowledge was seen as a method towards achieving rights-based health, as it supposedly encouraged a more representative, inclusive, and democratic participation of voices often marginalized or given less weight than those of the elite or powerful in society. It is associated with an inclusive vision pro-poor development that recognizes the agency of the poor (Mitlin & Patel, 2005).

Chowdhury et al. (2021) updates earlier definitions with a deeper exploration of what precisely constitutes a grassroots organization. They claim that what differentiates a grassroots organization is not only the representation of on-the-ground voices most affected by a given issue, but that the organization is led by and responsive to these groups. Grassroots organizations are "not only mission-driven but also represent their local constituents' core values and interests, often as a response to dissatisfaction with the status quo" (p. 423). The authors called them "fringe stakeholders," highlighting four key characteristics that distinguish a grassroots organization from an NGO or a social movement: locality, authenticity, moderate formality, and a lack of resources. Both South Africa and India have robust histories of grassroots organizations and local organizing, from decolonization movements to contemporary activism for socioeconomic issues such as housing rights, women's rights, environmental justice, and access to healthcare. In their review of "Grassroots Movements in the Global South" commissioned by USAID, Adhikari et al. (2017), the authors identify and articulate characteristics of grassroots movements across different world regions. In India, "rights to information, work, and food" were obtained through a combination of elite lobbying and grassroots mobilization (p. 16-17). Here, a federal democracy and the expansion of local governance invited participation and movements at the grassroots (p. 19). In sub-Saharan Africa, coalition building, learning from past movements, and autonomy from donor and state influence has driven the success

of some social movements, including the movement for adequate and affordable housing in South Africa (p. 21-22). Much of the research on grassroots social movements has been conducted based on examples from the US and Europe (Van Til et al., 2010; Rothschild & Leach, 2008; Hart et al., 2020), yet fewer authors have tempted to theorize holistically on such movements in the Global South. My research recognizes the need for a different framework to understand the role of the grassroots in the South, particularly in challenging development aid narratives and operating under tight resource constraints.

Meanwhile, "community health" represents a related but distinct concept to "grassroots health," which often arises in the context of democratizing health governance and making health processes more transparent and inclusive. The idea of capacity-building in the community emerged in the 1950s and gained traction in the 1980s and 1990s, during the rise of NGOs as an alternative to bilateral and multilateral aid (Craig, 2007; Peters et al., 2021; Appe, 2020). Gaudillière et al. (2021) examine the role of community health during the Covid-19 pandemic in their book *Pandémopolitique*, which takes a critical look at the interaction of politics and health through triage during the pandemic. They define community health as a health approach that relies on preexisting social ties, local competencies, and grassroots knowledge to implement preventive health and public health measures (Gaudillière et al., 2021, p. 227-228). Community health alleviates the burden of healthcare on professionals and hospitals, allowing for decentralized decision-making, prioritizing prevention, and improving trust in the healthcare system. They depict some early community health experiments in the form of free clinics and volunteer medicine as "militant act[s]," citing the Haight Ashbury hippie clinic in 1967 San Francisco and the Black Panthers' community health centers as examples (p. 229-231). By rendering healthcare free of cost, universal, and controlled by the community, these interventions upheld local aspects of care and the power of community with the goal of protecting marginalized and underprivileged people's right to health. This form of community health goes beyond democratic representation in health, instead transferring control to people and patients to allocate health resources and subvert power (p. 248). Thus, community health is "more like a toolkit than a defined concept," simultaneously capturing elements of social medicine, preventive medicine, and primary health care (p. 248). The authors underscore that sharing decision-making with patients "opens space for discussion, reflection, and

negotiation" as an alternative to unilateral decision-making by healthcare professionals and institutions (p. 256).

It is important to take into account the common challenges faced by grassroots and community health initiatives. Due to constraints in resources, funding, and personnel, there is often a limit on what grassroots movements or innovations can achieve without external help. Grassroots groups can represent the interests of the populist few, rather than reflect the needs, desires, and opinions of the many as in a true democracy (Roberts, 2006). Furthermore, they are vulnerable to co-optation by donors, states, and other external influencers (Adhikari et al., 2017). This includes co-optation and romanticization of the vocabulary of local interventions by multilateral aid institutions. Critiques of community health came to the forefront during the Ebola crisis of 2013-2016 in West Africa. In their reflections on the engagement of communities during the epidemic, Wilkinson et al. (2017) described "the mismatch between communities as imagined in external interventions and official reflections on them, and the more complex relationships that existed on the ground" (p. 2). They demonstrated that the term "community" carries assumptions of warmth and solidarity in opposition to formal state structures, whereas its actual meaning is complicated by the diversity of identities, relationships, and inequalities that can exist within the bounds of one locale or social group. As some scholars have pointed out, overlaying the framework of "managerial professionalism and measurable outcomes" (Marberg et al., 2019, p. 127) over grassroots and community-based interventions "provides only a limited, instrumental approach to understanding organizational activity and leadership" (Appe, 2020, p. 336). These are pitfalls I wish to avoid and reflect upon as I investigate the grassroots and community-based aid ecosystem of my country cases.

2.3 De-Politicizing and Re-Politicizing Health: Challenging Neoliberal Narratives

If the momentum behind rights-based health gained ground in the mid to late-twentieth century, the overwhelming force of neoliberal capitalism and its internal logic pushed any utopian ideals of "Health for All" aside in the 1980s into the early 2000s. Many Global South countries, coerced by the Washington Consensus and pressured externally

and internally to "catch up" to developed, economic superpowers, began a process of structural adjustment and austerity measures, downsizing the public sector and promoting the private provision of services. These policies led to widening gaps between social classes and further marginalized those without access to wealth and resources (Serra & Stiglitz, 2008; Carroll, 2010; Basilico et al., 2013; Escobar, 1992). By framing health as a commodity sold on the free market and highlighting the profitability of the private health sector, the neoliberal narrative cut public financing of public health sectors and put the impetus on individuals to pay for and access their own healthcare (Basilico et al., 2013, p. 88-93). Global health aid began to take on a logic of limited resources and cost-effectiveness, whittling projects down to vertical or technology-based interventions once again. Primary health care lost its holistic nature as the global health community turned to the seemingly more affordable "selective primary health care," which limited funding for the most "cost-effective" primary health programs and interventions. This section aims to examine the normalization and institutionalization of this neoliberal hegemony and show its de-politicization of poverty, access, and social determinants of health.

In his critique of global health governance, Hunsmann (2016) described the discourse of global health as a consensus narrative of "a conflict-free world in which a variety of benevolent public and private players act in concert to improve population health in the global South" (p. 799). Yet constructing and choosing public health policies necessarily results in the confrontation of "conflicting interests of different patient and population groups" (Ibid). The author draws from empirical analysis of the international AIDS-control efforts in Tanzania to demonstrate the structural neglect of inequality-related conflicts through a process of "depoliticization" (Hunsmann, 2016, p. 799-800). During this program, AIDS prevalence was framed as a problem of sexual behavior rather than one of socio-economic power relations, inequalities in access to HIV prevention and treatment services were ignored, and decision-making was limited to institutional fora with little space for democratic input. International donor influence, which accounted for a large part of national AIDS response funds, meant that decisions were made in closed-door meetings between donor representatives and Tanzanian AIDS officials, cutting out the Tanzanian people and people with HIV/AIDS from the process. The need for "evidence-

based" responses justified the suspension of public accountability in favor of quick, vertical interventions (p. 807).

Through a process the author calls "deconflictualization," dominant groups constructed "an artificially harmonious, non-confrontational vision of health policy-making" (Hunsmann, 2016). By blaming sexual promiscuity as the cause of the HIV/AIDS epidemic, they distracted from examining power structures that perpetuated and worsened illness. By rendering the deliberative process exclusive and opaque, decisions could be made without democratic scrutiny, shrinking the space for opposing voices or alternative solutions. In this way, the case of AIDS response in Tanzania reflects a tendency in global health to fail to address the structural causes of illness, such as clean water, sanitation, adequate housing, food security, and access to primary care. However, tackling these determinants of health require a major shift in the allocation of resources, a fundamental challenge to established hierarchies, and political subversion. Drawing from Schrecker (2012), the author calls attention to the phenomenon of "learned helplessness with respect to economic and social policy" among global health practitioners. Many international organizations and political institutions do not engage in the kind of policy debates, alliances, and resistance necessary to address cross-cutting crises that threaten population health in the Global South (Hunsmann, 2016; Schrecker, 2012). Thus, positive change in global health will come about "not through disease control programs, but through social struggles" (Hunsmann, 2016). Hunsmann calls for renewed attention to decision-making in health and the formulation of public health policies through democratic contention. He emphasizes that while these spaces for public debate will not emerge overnight, they can be encouraged by prioritizing transparent policymaking and embedding global health projects in already-existing domestic political institutions.

Appadurai (2000) provides a foundation for rethinking local social mobilization in the context of rapid globalization. In his seminal article "Grassroots Globalizaiton and the Research Imagination," the author describes a "double apartheid" brought about by globalization: 1) the increasing gap between academic and high-level debates and vernacular discussions about globalization worldwide and 2) the distance between the poor and their advocates and the intricate policy discourses occurring at national and global institutions (p. 2). Thus, he highlights the importance of an alternative or countervailing

force. “Grassroots globalization” or “globalization from below” describes a “series of social forms emerging to contest, interrogate, and reverse” the alienation of globalization and “create forms of knowledge transfer and social mobilization that proceed independently of the actions of corporate capital and the nation-state system” (Appadurai, 2000). It is a response to the exclusion of ordinary people’s participation in global governance, global allocation of resources, and globalizing processes. Appadurai credits the role of creativity and imagination in grassroots globalization, which allows people to face and resist the adversities caused by globalization through protest, civic association, collaboration, seeking social redress, and various other activities. He spotlights NGOs as “central to globalization from below” in their ability to “mobiliz[e] highly specific local, national, and regional groups on matters of equity, access, justice, and redistribution.” Thus, Appadurai’s article complements Hunsmann’s claim that powerful changes in global governance will stem from people’s movements and democratized spaces for advocacy and civic dissent.

In addition to Appadurai, many authors have theorized on the type of social movements that occur in the Global South, many of which fall under the category of a “new social movement” (Osaghae et al., 2010; Lee, 2007; Ponna, 1993; Mullings, 2009). These “tend to lack clear organizational structures and internal bureaucracies,” forging “political identities and agendas both nationally and globally” (Thompson & Tapscott, 2010, p. 4). They also encourage “horizontal participation” through “linkages forged between mobilized citizens and communities at local, national, and global levels” (p. 3). Through collective power, social mobilization in the Global South aims to exercise often newly-gained democratic rights, expand the socioeconomic rights of citizenship, and translate them into material gains. Newell and Wheeler (2006) called this the “political economy of rights,” demonstrating that the access, distribution, and production of resources, with a focus on the relationship between rights and accountability, show that economic rights are indivisible from social, political, and economic rights. In the Global South, where traumatic legacies of colonization have perpetuated resource inequalities and reproduced unjust power structures at the national and global levels, social movements are often an extension of the struggle against colonialism and for access to state institutions and resources (Mushakoji, 1993; Osaghae et al., 2010). Social movement theory, as applied to the Global

South, will be crucial to the interpretation of the struggle for health rights in the past three decades and the ongoing grassroots responses to the Covid-19 pandemic today. At the same time, some of this theorizing can be removed from the everyday realities on the ground for NGOs, grassroots movements, and community-based groups, a gap which my research attempts to explore and bridge.

Two mutually reinforcing forces of globalization have shaped the global health narrative and counteracted the work of grassroots social movements. Qadeer & Baru (2016) illustrated the histories and staying power of neoliberalism and global health security in legitimizing the health reforms that occurred at the turn of the twenty-first century. The desire to attract private investment to health systems and the perceived scarcity of resources justified privatization and austerity measures in public health sectors around the world. Simultaneously, the emergence of health threats to the Global North like cholera, HIV/AIDS, SARS, and Ebola helped solidify global health security as a priority for the West. This preoccupation with global health security invited powerful private foundations, international finance organizations, and multi-national corporations into the space of global health decision-making. This securitization of global health appeals to the imperative for fast-moving, top-down methods of containment and control, diminishing the space for civic engagement and grassroots deliberation.

On the other hand, Qadeer and Baru (2016) pointed to the growing role of "global and national networks of NGOs, academics, and social activists who have questioned the ideology and evidence garnered by neoliberal health reforms." These activist groups and people's movements condemn state neglect and experiment with holistic alternatives to narrow health interventions. Much like Hunsmann (2016), they warn against the depoliticization of health, noting that the narrative of state reforms can easily be manipulated. Speer et al. (2014) also commented on the importance of examining community health in relation to public health, especially in efforts to reduce health inequity across racial, gender, and class divides. Similar to Appadurai (2000) and Qadeer & Baru (2016), they noted that globalization has shifted policymaking away from the local sphere. Echoing Qadeer & Baru (2016), the authors also emphasize that in a globalizing world, different coalitions must join together to acquire enough resources, legitimacy, and power to affect local change and achieve collective goals, rather than acting in isolation of one

another. My case studies, particularly the one on South Africa, show how this can be achieved without compromising on the missions and goals of each organization in a coalition. It is also important to acknowledge that empowering local responders, though a welcome rebalancing of power among global health institutions, can not address all the underlying problems and social determinants of health alone, without the help of the state, donors, and international actors.

2.4 What is "Public" in a Public Health Crisis?

Linked to the intersection of community health, public health, and health governance is the central question posed to many public health institutions today, i.e. "What is 'public' in public health?" (Degeling et al., 2015; Coggon & Gostin, 2012; Mold et al., 2019; Benjamin, 2006). Pre-Covid-19, this debate was often applied to formalized, civic and political processes of Western-based institutions, convening citizen health committees to make decisions or implementing programs to increase citizen engagement and social accountability in health institutions (Fischer-Mackey et al., 2020; Bréchat et al., 2014; Falleti & Cunial, 2019; Renedo & Marston, 2011). Many studies have asked whether such public participation initiatives add value to public health delivery and how public health institutions can best reflect citizens' voices. Bréchat et al. (2019)'s paper on the "Arucah method" demonstrated one concrete example of an initiative to put the public back in public health. Its five steps for defining health priorities allows citizens to bring bottom-up knowledge to authorities at the top, through a systematic process of survey, citizen prioritization, internal debate, public debate, and evaluation. Its value stems from the acknowledgment of diverse opinions without expectation of consensus, the open dialogue between citizens, healthcare workers, and elected representatives, and the divorce from arbitrary decision-making and "medical paternalism" (Ibid.). One major goal of this discourse is empowerment of those who access healthcare, so that healthcare receivers can reclaim some autonomy and agency in a sometimes unchanging and opaque healthcare system.

While this public health debate has often operated on a formal academic and institutional public health plane, the Covid-19 pandemic has raised some practical

questions as to how much a citizenry has a say on the public health measures imposed on them. Due to the global reach of the pandemic, this public health problématique has grown into a global health quandary. In an open call to action for world leaders at the UN General Assembly in December 2020, a group of health academics and practitioners, collectively called "Reclaiming Comprehensive Public Health" (RCPH), proposed ten principles to "bring the public" back to public health amidst the Covid-19 crisis (RCPH, 2020). These principles included broad measures such as engaging the community in pandemic response and providing economic and social support for those negatively impacted by pandemic safety measures. In an accompanying opinion piece by two members of the RCPH group, Buse and Aftab (2020) deliver a scathing condemnation of the disempowerment, alienation, and criminalization of people and communities as a result of lockdown measures around the world. In the context of the Covid-19 pandemic, "What is public in public health?" takes on new weight and urgency, as health governance systems around the world wrangle with implementing the most effective yet humane responses to this emergency.

I bring this Western-conceived debate of defining the "public" in public health not to impose a Western conceptualization of healthcare and health institutions on the global South, but to discover how global South localities conceptualize and define their own public participation in health institutions. In a country like South Africa, civic engagement with political institutions often takes on forms of protest, legal activism, grassroots movements, and various forms of rights-based contestation as they constantly mold and reshape national democracy to fit their local needs. In some Indian states, decades of experience with federalism and decentralized models of public health governance and delivery have already inscribed local politics and local debates into the public health system. Thus, my thesis presumes not that this public health debate can add to global South development, but rather lessons learned from the grassroots in the Global South can help Western institutions and the global North in their quest to discover the public in public health.

Nonetheless, the challenges of crisis management pose a problem to democracy everywhere, North and South. Boin et al. (2005) define a crisis as "a serious threat to the basic structures or the fundamental values and norms of a system, which under time pressure and highly uncertain circumstances necessitates making vital decisions" (p. 2).

Delivery of aid is complicated by destabilized infrastructure, limits on supplies and transportation, lack of coordination, and insufficient information, thereby slowing the process of disaster relief (Decker, 2013). A serious public health crisis justifies some suspension of normal policy-making processes in favor of more timely and efficient measures to stop the spread of disease. As the authors rightly emphasize, “a high degree of uncertainty” exists during a crisis, in which crisis leaders must somehow make sense of what is happening and what will happen in the future (Boin et al., 2005, p. 2). They have the impossible task of making tradeoffs and assessing the costs and benefits of action or non-action based on hypotheticals. However, I argue that there remains space for public discourse and public deliberation while providing a quick humanitarian response, through the engagement of on-the-ground, community-based, and grassroots responders. In their book, Boin et al. (2005) focus primarily on formal leaders’ response to crises, including "presidents, prime ministers, cabinet ministers, senior civil servants, and public managers.” I argue that what they term local or “situational leaders” responding on the ground are in fact the primary leaders of a public health crisis when the state does not have the resources or political will to help everyone, such as in the global South. In the context of an informal settlement in a nation where the central government's resources are spread thin and poor or informal workers are often neglected, the volunteers, activists, and civil society actors become the policymakers during a crisis. They are the ones deciding where to put the soup kitchens, who should receive sanitation kits, what information should be transmitted, and how much money to allocate to which programs.

No doubt the “crisis” in a “public health crisis” poses major ethical and logistical challenges to leaders and practitioners. Slow, public deliberation and debates may not be possible. However, consultation with those receiving care and social aid should not be sidelined, even in the face of crisis. Furthermore, the Covid-19 pandemic poses a window of opportunity to reexamine “putting the public in public health,” to challenge the way things have always been done, and to rethink a health system in which communities and people are heard. Gaudillière et al. (2021) demonstrated how the process of clinical triage during the Covid-19 pandemic reflected the underlying stratifications and structural inequalities in French society, advocating for a more communal and inclusive reinvention of the French healthcare system. Through the questions raised by the Covid-19 crisis, I

would also like to develop a more community-driven, inclusive, and activist approach to global health and health crisis response. My work synthesizes the ample literature on rights-based global health, grassroots organization, new social movements, and Global South studies and views them through the lens of the unique challenges of the Covid-19 pandemic.

CHAPTER 3: SOUTH AFRICA

"You plan alone. You are planning without me. If you're planning for the communities, we must plan together."
– Zakuthini Ndletyana, Khayelitsha CAN activist, from the documentary film *Cape Town Together*

The Covid-19 crisis in South Africa played out against a backdrop of strong rights-based advocacy and a robust civil society, albeit in a country rife with inequality. In this chapter, I analyze the quality of the national Covid-19 response in South Africa, evaluating its ability to preserve human rights while keeping case numbers low. Then, I examine the history of informal settlement inequality, taking time to describe Vrygrond, an informal settlement in the Cape Town municipal area where many local Covid-19 interventions were carried out. Having built a foundational understanding, I begin to describe the nature of the South African grassroots and community-based responses based on my interviews and case study materials. My interviewees primarily consisted of participants and volunteers for Community Action Networks or CANs (grassroots collectives movement started in Cape Town), Amava Oluntu (a community

development NGO based in Vrygrond), and various community kitchens throughout Cape Town. They ranged from volunteers who simply helped out where they could like Noleen, who volunteered with Amava Oluntu to make food deliveries to community kitchens, to health academics like Manya van Ryneveld, who was one of the original health practitioners that founded the CANs. Through their narratives, I construct a nuanced portrait of unprecedented grassroots solidarity, community responsiveness, and radical inclusivity, analyzing their activities through the lens of food insecurity and participatory democracy.

3.1 National Covid-19 Response in South Africa: A Rights-Based Approach?

On March 5, 2020, South Africa reported its first confirmed case of Covid-19 (Wiysonge, 2020). By March 15, the South African government had declared a national state of disaster and installed a national Covid-19 command council led by President Cyril Ramaphosa. At the time, South Africa was often praised for its swift and centralized campaign against the spread of Covid-19 focused on flattening the curve of Covid-19 cases. Social distancing was implemented, including school closures and a ban on gatherings of over a hundred people. Government officials were banned from non-essential travel and travel to high-risk countries. From the beginning, the South African minister of health organized a press briefing to confirm the first case and published subsequent daily press releases to update the public on the Covid-19 situation in the country. The health ministry launched an extensive and multilingual social media and press campaign to keep South Africans informed on Covid-19 preventive measures, combatting misinformation and disinformation around the disease.

Between March 26 and April 16, 2020, the national Covid-19 command council implemented a 21-day lockdown, requiring South Africans to stay home except to obtain food, medicine, fuel, or other essential goods and services (Wiysonge, 2020; Foundation for Human Rights, 2020). The sale of nonessential goods was paused during this period, including the sale of liquor and cigarettes. Borders were kept closed and quarantines were required for returning travelers. The army, along with the police, were tasked with

enforcing the lockdown order. When the first lockdown came to an end, the government announced a 5-level lockdown system, meant to balance public health with economic interests, where restrictions increase or decrease based on the current epidemiological trends in the country (Foundation for Human Rights, 2020). For example, at levels 4 and 5, social gatherings and exercise outside are banned. At level 3, only those with valid permits for work or school can travel between provinces.

Figure 1: Trajectory of South Africa's Covid-19 Lockdowns in 2020

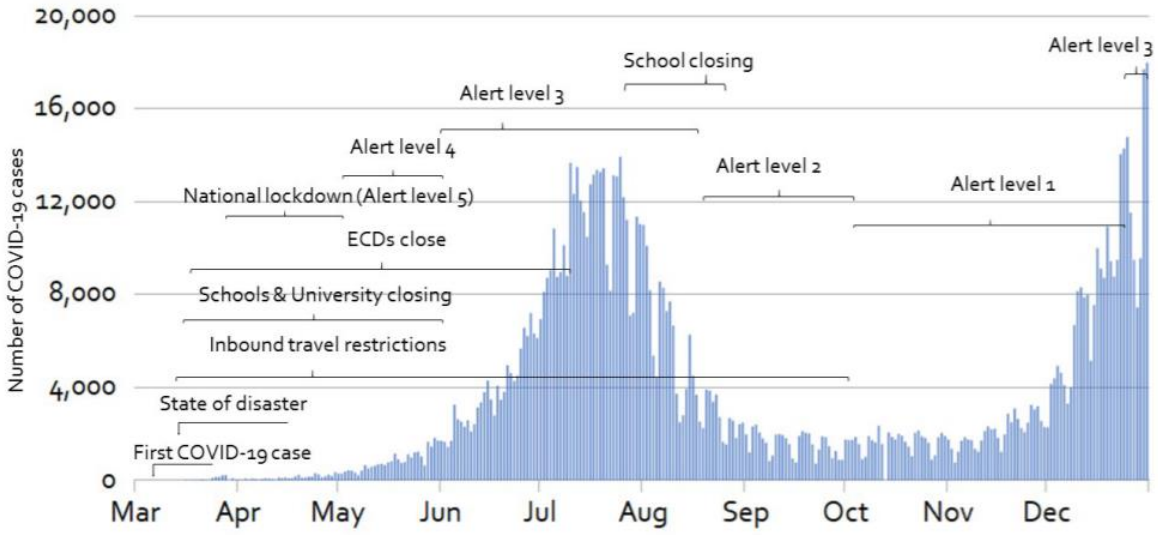

Figure 1: Overview of COVID-19-related alert levels and daily reported infections in South Africa. The first COVID-19 case in South Africa was reported on 5th March 2020. The World Health Organisation (WHO) declared a global pandemic on March 11th. South African president, Cyril Ramaphosa, declared a national state of disaster on March 15th and imposed a lockdown on March 27th.

(Paganini, 2021)

While these measures were lauded by some as swift and decisive governance founded on principles of evidence-based epidemiology, they have since been criticized by human rights organizations and civil society as draconian, infringing on civil rights. A 2020 Foundation for Human Rights report demonstrated the ways in which the lockdown exacerbated inequalities and socioeconomic differences already existing within South African society (Foundation for Human Rights, 2020). Perhaps most catastrophically, the

restrictions on people's ability to work left many unemployed and deprived of a source of income, paving the way for rampant food insecurity. These measures were particularly consequential for the millions of informal workers and residents of informal settlements, who faced high levels of unemployment, food insecurity, and poverty before Covid-19 arrived in South Africa.

The South African Police Service (SAPS) and the South African National Defence Force (SANDF) were deployed to maintain law and order and enforce the lockdowns (Foundation for Human Rights, 2020). According to an article published by the *New Straits Times*, the deployment of an additional 73,180 SANDF troops to enforce the Level 5 lockdown in April 2020 was the "largest deployment of SANDF troops in post-democratic South Africa" (AFP, 2020; Trippe, 2020). To devastating effect, these organized forces received limited guidelines on lawful and expected behavior when interacting with citizens. On August 26, 2020, the murder of Nathaniel Julies, an unarmed 16-year-old boy with Down's syndrome, sparked national protests against police brutality, as reported in a *Foreign Policy* article (Egwu, 2021). Unfortunately, such instances of extrajudicial killings were common in enforcing lockdowns. According to data from the Independent Police Investigative Directorate, the SAPS killed a person every 20 hours on average in 2020 (IPID, 2020; Clarke, 2021). Far from a recent phenomenon, the inhumane actions taken by the South African police stem from a long legacy of violent and unethical behavior. During apartheid, the SAPS were engaged in dominating and discriminating against Black South Africans and capturing enemies of the regime (Egwu, 2021). While some improvements in community policing, demilitarization, and human rights training occurred in the first years after apartheid, these goals were brushed aside as the required training for police was reduced from two years to one and corruption discredited the recruitment process. Furthermore, a culture of impunity and cover-up runs rampant, which allowed the police to initially claim that Nathaniel Julies was caught in the middle of a gang fight. The lack of training and control of armed forces likely contributed to the documented human rights abuses and violations by South African law enforcement, especially due to their disproportionate presence in under-resourced areas and informal settlements. Meanwhile, the widespread mistrust in the SAPS raises the question of whether using them to enforce stringent top-down lockdowns was the best policy across South Africa.

3.2 Informal Settlements

Due primarily to legacies of colonization and apartheid, South Africa remains one of the most unequal societies in the world. According to the World Inequality Lab, wealth inequality has not decreased in the country since the end of apartheid (Sguazzin, 2021). The richest 10% of the population owns over 85% of household wealth. These disparities are highly visible in urban communities, as middle-class and wealthy neighborhoods are juxtaposed next to shantytowns and informal settlements, spatial stamps of colonialism. In 2018, about 25.6% of urban dwellers were living in informal settlements in South Africa (World Bank, 2018; Trading Economics, 2021). During apartheid, non-white South Africans were barred from housing, education, and job opportunities, leading many to congregate in informal townships around major cities (Cape Town Project Center, 2014). Informal settlements suffer from unequal access to running water, sanitation, electricity, employment opportunities, food security, and internet and technology. According to a profile in *Borgen* magazine, this lack of resources can foster civil unrest, as shack-dwellers from various informal settlements have led protests against the government demanding access to housing, sanitation, and basic resources (Laframboise, 2019). Marginalized from formal political processes, these shantytowns are seen as hubs of defiance against authorities that neglect or actively exclude these under-resourced areas from important decision-making, as noted in an academic article on informal settlements and Covid-19 (Van Belle et al., 2020). The authors note that informal settlements present a double challenge of preventing the spread of disease but also continuing to ensure access to food and basic necessities despite business closures and restrictions on informal work.

VRYGROND / CAPRICORN

Figure 2: Map of Seawinds and Vrygrond Communities

(Battersby & Marshak, 2013; Google Earth)

My case study focuses primarily on the hub of grassroots activities in the Cape Town municipal area, where Community Action Networks (CANs) first began, and several community kitchens and food relief initiatives actively responded to the crisis. Most of the community-based organizations highlighted in the discussion below operated in and around the Vrygrond informal settlement. By providing a description of this particular informal settlement, I hope to link my analysis of grassroots activities to an analysis of place and history of a community. Vrygrond or Capricorn contains five large shantytowns located on the Eastern Cape side of the greater Cape Town municipal area (von Kotze, 2014). These shantytowns, Village Heights, Hillview, Militar y Heights, Overcome Heights and Cuba Heights, were home to over 6000 people by the late 1990s and were estimated to accommodate around 35,000 people by 2014. However, these numbers are difficult to confirm through an official census, and some claim that there are several more residents unaccounted for by the government. The development of the communities was shaped by the history of apartheid and segregation in South Africa that increased and aggravated rural-to-urban migration, unemployment, and housing insecurity. It is one of

the oldest informal settlements in the Western Cape, with the first wave of residents arriving in 1942, making their living as "trek" fishermen and setting up informal houses by the beach (von Kotze, 2014; Living Hope, 2021). In the 1970s, due to the apartheid regime, many Cape Town residents were uprooted from their homes and moved to blocks of apartment buildings in Lavender Hill.

A 1984 research report on development in South Africa described the areas of Vrygrond and Lavender Hill as "one of the most dangerous areas of the Western Cape" (Naidoo & Dreyer, 1984). Their paper describes a community rife with gang violence, unemployment, poverty, and crime. Buildings and houses were constructed "entirely by the scraps of material which go into its structure pieces of corrugated iron, old tins and drums, rough boughs, sacking, anything which can possibly offer protection against the weather" (1984). They detailed incidents of residents receiving far less than the market price for their land, and if they resisted, forced evictions by the government. Constantly harassed by the authorities, who would demolish homes in an effort to turn residents away, some settlers chose to leave while others reconstructed destroyed homes clandestinely at night (Living Hope, 2021). The unjust spatial distribution of the Muizenberg area also reflects a pattern of colonial urban planning, through spatial control and land dispossession, in which an affluent central business district is surrounded by under-resourced and dispossessed townships, a topic written about extensively in the academic literature (Strauss, 2019; Dirsuweit, 2009).

While the study was completed decades ago and some conditions have improved, there is little reason to believe that the basic structural disadvantages contributing to the under-resourcing and impoverishment have radically changed. At the time that the Covid-19 pandemic arrived in South Africa, Vrygrond was still overcrowded and battling very high unemployment rates, reportedly around 70% to 83% (von Kotze, 2014; Living Hope, 2021). Electricity and access to clean water continue to pose a problem, which also intensified during the Covid-19 lockdowns (Living Hope, 2021). Shacks are still mostly constructed from available materials, often tin and wooden boards, which offer little protection against cold weather, wind, and rain. One NGO worker who helped provide Covid-19 relief described Vrygrond as "more difficult" than "other wealthier informal settlements" (Interview. Teresa. July 1, 2021).

However, since the publication of the Carnegie Conference report painting a grim portrait of an informal settlement in crisis, the anti-apartheid movement kindled a spirit of hope and activism, particularly for informal settlements. Many researchers, NGOs, activists, and media publications have directed attention at communities like Vrygrond and Vrygrond itself, encouraging donations, aid, food kitchens, and community development initiatives over recent decades. For example, prior to the pandemic, Amava Oluntu, an organization which will be discussed in more detail below, identified youth changemakers in the community and worked with them on community-based projects. This is not to claim that all of these aid initiatives were beneficial or successful, but it is important to note that a handful of bottom-up community projects have been initiated in informal settlements, reflecting the will of informal settlers to better their lives and living situations. This motivation came to full force and drove the many impressive and successful relief initiatives and activism that characterized the South African Covid-19 response. The mobilization around the issue of deteriorating food security during the national lockdowns proves to be a converging point of underlying determinants of health, humanitarian action, and human rights contestation.

3.3 Food Insecurity: Community Action Networks, Cape Town Together, and Amava Oluntu

Many researchers and practitioners have identified a lack of income and acute food insecurity as two of the most detrimental impacts of the lockdowns in South Africa (Spaull et al., 2021; Mohamed et al., 2021; IPC, 2021; Berg et al., 2021). Using data from the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) in South Africa, researchers have found that hunger and food security increased during the pandemic due to "disruption of food intake or eating patterns because of lack of money and other resources" (Berg & Patel, 2021; Berg et al., 2021). According to the report on the first wave of Covid-19, 47% of survey respondents said that they ran out of money for food in April 2020 (Spaull et al., 2020, p. 6). The shuttering of schools suspended the government's national school feeding scheme, depriving nine million children of a reliable source of daily school meals, as reported in the *University of Cape Town News* (Seekings,

2020). While this food insecurity appears most severe after the first wave of lockdowns, unfortunately "household hunger" and "child hunger" have not eased even throughout more recent lockdowns, according to a NIDS-CRAM report (Berg et al., 2021). Furthermore, hunger was most severe among Black Africans in South Africa in every Covid-19 wave, with "bigger households" and "households in traditional areas" most likely to run out of food and go hungry.

Access to food, particularly access to a variety of nutritious food, is a particularly important component of the right to health as a basis for human survival and dignity. Although the "right to have access to sufficient food and water" is promised to everyone under the South African Constitution (South African Human Rights Commission, 2012), the government failed to prepare for the massive scale of food insecurity, even as they placed the country under lockdown. In restricting the operations of the informal food sector, the South African state demonstrated its lack of understanding of local and informal food systems and their impact on people's lives, livelihoods, and food security. While large supermarkets were allowed to remain open, smaller convenience stores (spaza shops), street vendors, and small-scale traders, who supply 70% of low-income households with affordable food (Paganini et al., 2021), were forced to suspend business according to several news articles (Mokgabudi, 2020; HSRC, 2020). Interviewees living in South Africa at the time mentioned the high cost of groceries from the supermarkets (Interviews. Chrislyn and Nomonde. July and November 2021.) and the tendency for retail supermarkets to be located in affluent areas (Interview. Haidee. November 8, 2021), while several news sources cited sustained price hikes of essential food products in South African supermarkets (Business Tech, 2020; Reddy, 2020). As reported by NGO responders and Cape Town residents, access to a variety of fresh, nutritious food, such as fresh fruit and vegetables, eggs, meat, fish, and diary, were cut off or made unaffordable (Interviews. Chrislyn; Nicole, Nomonde & Haidee. July and November 2021.). Cape Town community kitchens struggled to access, purchase, and deliver the necessary ingredients to produce balanced, nutritious, and filling meals for their communities (Interviews. Noleen; Teresa; Chrislyn and Marlene; Danny. June to November 2021.).

The South African government has attempted to provide financial aid and food relief to those in need during the Covid-19 crisis. The largest form of support came from

South Africa's notably extensive social grant system, which was already in place before the pandemic (Berg et al., 2021). However, the pandemic and lockdowns prevented distribution of these grants to all who were in need. Due to the severity of the crisis, the government increased the top-ups for existing grants and introduced two new grants – the Temporary Employee/Employer Relief Scheme (TERS) and the Covid-19 Social Relief of Distress Grant (SRD). President Ramaphosa also announced a food parcel relief scheme in April 2020, which aimed to deliver food aid packages to vulnerable households (Vermeulen et al., 2020). For example, in Gauteng province, parcels were available to all households earning a combined income of less than R3,600, as well as to recipients of South Africa's social security pensions, disability, child welfare, and military veteran grants. During my interviews, many community kitchen workers in Cape Town noted the inadequacy or simply the absence of food parcels from the government even after months of lockdown, particularly in Vrygrond (Interviews. Noleen, Teresa, Danny, Nolubabalo. June-November 2021.). As reported in Paganini et al.'s (2021) food agency study, low-income households came to rely on food aid during the lockdowns, "which [was] either not enough, innutritious, subject to corruption and patronage, or inaccessible" (p. 2).

Gaps in the government's food relief response left space for grassroots organizations to expand their operations and attend to the immediate needs triggered by the pandemic and the ensuing lockdowns. Across the Cape Town municipal area and beyond, Community Action Networks (CANs) sprung up to mobilize volunteers, coordinate relief responses, set up community kitchens, and disseminate important public health information (Cape Town CANs, 2020). In her journal article on digital platforms as democratic interfaces, Odendaal (2021) shows how they began as informal groups of "health professionals, teachers, activists and artists" on WhatsApp used to build solidarity "across class and race lines" around the suffering instigated by the public health crisis and lockdowns. According to an *Open Global Rights* online article, the CANs gathered people of all backgrounds, from those with no volunteer experience to seasoned community organizers, towards responsive and effective community-led aid (Scheepers et al., 2020). The CANs "aimed to encourage and inspire people from all over the city to self-organise, to take local action, and to develop ways to share resources" (Scheepers et al., 2020). Furthermore, the CANs were built on principles of horizontal participation, critical

relationships over critical mass, collective consciousness, and "moving at the speed of trust" so that trusting relationships were established before taking action (Scheepers et al., 2020). In this way, different kinds of knowledge and experience are weighed equally, highlighting the importance of indigenous knowledge and community knowledge outside of formal professional experience. As stated by a Woodstock CAN activist in the documentary film *Cape Town Together*, "Hierarchical systems are patriarchal systems" (Brady & Valley, 2021). From its initiation, the CANs were envisioned as radically anti-hierarchical systems of organizing, without gatekeepers or chains of command, in which no one participant had more decision-making power over another.

In an article for the *Daily Maverick* written by CAN activists of Cape Town Together, they described their activities as such:

> "There is no "one size fits all", as every neighbourhood is different. Some CANs have set up mask-making and distribution schemes. Others have opened community kitchens that provide hot meals to thousands of people every day, while also being sites for communicating and demonstrating Covid-safe practices, including handwashing, mask-wearing and physical distancing." (Cape Town CANs, 2020).

Various CANs have also connected homeless people to temporary accommodation and employment opportunities, organized community clean-ups, initiated community gardens, collected donations for households affected by evictions and flooding, assisted school children in their home-based learning, and provided new mothers with "baby bundles" of supplies (Cape Town CANs, 2020). One of the missions of the CANs was to build solidarity networks throughout a community, identifying vulnerable populations and connecting smaller, under-resourced organizations with larger organizations that could help. Notably, a lack of hierarchy or formal leadership led to new and innovative ways of organizing. As described during an interview with Manya van Ryneveld, a health systems researcher embedded in the Cape Town CANs' activities:

> "One of the principles was this idea of flexibility… if there was a need for something, we would respond to it by setting up some kind of organizing node. And as soon as that need disappeared or changed, the node could fall away or people would move on to other things." (Interview with Manya. December 1, 2021).

To give an example, Manya described the case of several informal settlements in the Khayelitsha township that demanded their right to water from the city, a story that was also chronicled in the *Cape Town Together* documentary (Interview with Manya, 2021; Brady & Valley, 2021). Since Khayetlisha residents had lacked running water even before the pandemic and now could not leave their homes to access water sources several kilometers away due to lockdown restrictions, they demanded that city officials fulfill the township's right to clean water. An organizing node was set up to stage demonstrations, map access to water in the community, and report it to the municipal government. Eventually, the city set up water taps in the informal settlements, and the CAN organizers that had been in charge of this issue disbanded. This demonstrates the highly flexible and transient nature of the CANs and their activities, a strategy that has been successful when attempting to achieve such local, tangible goals.

One example of a civil society organization that was part of this solidarity network is a community and youth empowerment organization called Amava Oluntu, which roughly translates from isiXhosa to "life experience or wisdom of the people" (Amava Oluntu Facebook, 2021). The organization's "About Us" web page describes itself as "a collective of individuals and groups working together to create spaces that encourage reconnection of individuals to themselves, each other and the natural world" (Amava Oluntu, 2020). Headquartered in Muizenberg, it operates mostly in the nearby shantytowns, particularly the Vrygrond informal settlement. It originally focused on supporting youth-led initiatives from the Vrygrond community built on long-term sustainability and strong partnerships with a social justice lens. For example, one major project teaches its youth participants video production to be able to tell stories about their communities through documentary films.

However, since 2020, the organization has pivoted to respond to the threat of the Covid-19 crisis and national lockdowns. Together with Muizenberg CAN, Amava Oluntu has supported the youth-led cooperative Vrygrond United 4 Change to support community kitchens and food commons projects responding to the increase in food insecurity after the first lockdown (Amava Oluntu, 2020). Amava Oluntu supported 15 of the 30 community kitchens in Vrygrond, each serving an average of 150 meals per day. It provided them with administrative support, such as fundraising, financial management, and strategy development. It also helped the kitchens obtain permits, advised them on legal and health and safety measures, and worked with them to develop an inventory and ordering system to ensure well-stocked kitchens. In interviews with the leaders of two small community kitchens in the area, Harmony's Angels and Muiz Kitchen, both expressed gratitude towards Amava Oluntu for helping them obtain funding, supplying them with food, and navigating complex bureaucratic procedures (Interviews. Chrislyn; Michael. July and November 2021). Amava Oluntu also supported efforts that look towards long-term food sustainability, such as establishing small gardens, while seeking a larger tract of land to support a larger-scale food growth initiative (Amava Oluntu, 2020). Taken together, the layered ecosystems of local community kitchens, resourced NGOs, and CANs worked together to create spaces to address food insecurity and other inadequacies.

3.4 Grassroots Solidarity in Cape Town: Invited v. Invented Spaces

When the state failed to adequately respond to the food crisis, grassroots and community-based organizations became the substitute. Not only were these organizations filling in the gaps, for some communities in Cape Town, these informal coalitions of NGOs, CBOs, philanthropic organizations, and activist groups became the food system that sustained neighborhoods and kept people alive. CAN participants and NGO workers have expressed an awe and reverence for the speed and scale at which these initiatives mobilized to feed and provide aid for others within their community. One volunteer food deliverer for Amava Oluntu expressed feeling "amazed" and "impressed" at how communities were able to independently "pull together" (Interview. Noleen. June 29, 2021.).

As another volunteer for Amava Oluntu noted of the initial call to action by community members to respond to the crisis:

> "There was a great level of enthusiasm. And there was a lot of people thinking about how to help, what kind of ways can we create, what kind of new systems are needed and how can we make sense of what is happening. So, it was definitely a great level of enthusiasm that made us really proud to be part of that moment." (Interview. Teresa. July 1, 2021.)

This solidarity and sense-making at the grassroots builds upon a strong legacy of grassroots activism in Cape Town and throughout South Africa. The country has a unique history of contested spaces, civic dissent, and social mobilization from the histories of decolonial, anti-apartheid, and pro-poor health movements. Due to the rights-based and inherently political nature of grassroots organizing in South Africa, particularly in informal settlements, the Covid-19 food relief response by the community was also a political one. Piper and Nadvi (2010), drawing from Cornwall's work on citizen participation (2002; 2004), demonstrated how South Africa's popular mobilization was a response to the inadequacy and poor design of "invited spaces," created by the state "from above" for constructive engagement between local actors and local governance, spaces which tended to be characterized by a lack of genuine political will and a failure to inspire change (p. 212-213). Instead, grassroots mobilization and community organization turned to "popular spaces," or "arenas in which people come together at their own instigation – whether to protest against government policies or the interventions of foreign powers, to produce their own services or for solidarity and mutual aid" (Cornwall, 2004, p. 2). These are invented "spaces of contestation as well as collaboration, into which heterogeneous participants bring diverse interpretations of participation and democracy and divergent agendas" (Cornwall et al., 2007, p. 2). The boundary between invited and invented spaces are not fixed, as popular spaces can become institutionalized and invited spaces can foster contestation, collaboration, and dissent among divergent groups (Cornwall, 2004). Such was the case earlier in South African history, immediately after the dismantling of state-sponsored apartheid.

When the African National Congress (ANC), which had been the Social-Democrat party of the struggle movement in South Africa, was formally recognized and voted into office in 1994, civil society underwent an accompanying transformation (Piper & Nadvi, 2010). Grassroots movements, which had previously been engaged with political anti-apartheid activism, were collectively absorbed into the newly recognized official politics of the ANC. NGOs were pressured to professionalize or reorient their activities from rights-based advocacy to a focus on service delivery (Greenstein, 2003; Piper & Nadvi, 2010). In short, the anti-apartheid movement, having won their victory through a formal desegregation and democratization of South African society, was pressured to de-politicize and cooperate fully with the new government. Since then, the ruling party has fumbled the fulfillment of citizen's basic socioeconomic rights, from the period of state-sponsored AIDS denialism in the late 90s and early 2000s to its failure to adequately address spatial injustice in informal settlements, accompanied by reports of widespread corruption and general incompetency (Fourie & Meyer, 2010; Strauss & Liebenberg, 2014; Budhram & Geldenhuys, 2018). Thus, social mobilization has since been rekindled in the form of protests, movements, rights-based organizations, and advocacy groups in response to disappointment and frustration with the state. These grassroots movements have re-politicized certain unfulfilled socioeconomic rights, including the right to food, building "invented spaces" of contestation away from formal politics and institutions.

The mobilization inspired by the pandemic, though centered around pandemic prevention and food relief, is a continuation of this tradition of invented spaces for civic protest and a contestation for rights. As stated by a CAN member in a *Daily Maverick* article profiling the work of Cape Town Together, "every loaf of bread is political" when taking action to address extreme hunger and poverty, a result of the state's failure to fulfill a constitutional right (Cape Town CANs, 2020). Cape Town Together's strength lies in its "non-partisan, non-religious and vigorously independent network not beholden to any political party, donor or organization" (Cape Town CANs, 2020), thus showing a strong resistance to institutionalization or co-optation by party politics. They have thrived on principles of intimate ties to the community, an organic and unregulated bottom-up power structure, responsiveness to the needs of the community, and co-learning across the network of organizations involved (Paganini et al., 2020, p. 81). Cape Town Together and

other South African CANs, as unconventional coalitions and mutual aid agencies, provide an alternative and complementary model to an over-reliance on top-down governance during a public health crisis. When state authorities left a vacuum of food insecurity, unemployment, and housing insecurity, these networks took on the responsibilities of the government and mobilized resources to provide aid to those in need. Beyond "evidence-based public health" and "state handouts," the government and the larger landscape of global health governance could do well to pay attention to the activities and the process of decision-making within the CANs to support the work of these "popular spaces" and improve models of pandemic preparedness.

3.5 Contested Governance in Informal Settlements: Tensions Between Government and Civil Society

Of the 11 interviews I conducted among civil society responders and food justice academics in South Africa, none of them expressed satisfaction with how the government handled lockdown-induced food insecurity. On the contrary, many expressed frustration with the government's unresponsiveness and hindrance to community food relief efforts. Noleen, a volunteer food truck driver for Amava Oluntu, mentioned "a sense that the government wasn't going to do anything, and we had to do something ourselves" as a motivating factor in taking action (Interview. Noleen. June 29, 2021). One volunteer with Amava, Nolubabalo, who lived in the Vrygrond informal settlement herself and saw the havoc that the lockdowns wreaked firsthand condemned the neglect of the government. She reported that "the governments said the food trucks had come" to deliver food aid, "but the community never saw it" (Interview. Nolubabalo. July 8, 2021). One staff member with Amava Oluntu, a German expat living in South Africa, stated:

> "I think that the government was picking and choosing existing organizations that were maybe bigger and then they helped them, but they didn't focus on bottom-up principles or community-based philosophies. They just sent out a lot of rules and regulations that you had to follow" (Interview. Teresa. July 1, 2021).

She went on to describe red tape imposed by the government during lockdown, which burdened community kitchens with the obligation to obtain permits and follow strict rules at a time when efficient and rapid food distribution was desperately needed. She stated, "They just came up
with rules all the time that you had to fight against," showing the tension between civil society and the government's public health measures during the Covid-19 response.

Furthermore, public health measures like physical distancing and frequent handwashing were perceived as "very irritating" to the people in Vrygrond (Interview. Teresa. July 1, 2021).

> "You cannot tell someone living in the town[ship] that they must do physical distancing. And I mean, how many people live in crowded communities like Vrygrond? There are so many people out there. And you just imagine being that person, like you'd just feel offended. And you're just like, what is happening? Like to wash your hands, I don't know, 20 times a day? How can you do that in a township?" (Interview. Teresa. July 1, 2021).

Evidence-based measures of restricting movement and enforcing social distancing, which are welcomed by global health organizations, world leaders, and governments worldwide, are seen as offensive and irritating when applied to those living in underprivileged communities like South Africa's townships. This sentiment can not be divorced from the distrust and resistance that has existed between South Africa's informal settlements and the government. Arguably, the explosive Jacob Zuma protests over the summer of 2021 reflect an undercurrent of tension between the government and the people, spurred by allegations of political corruption and exacerbated by the negative consequences of lockdown. The tension between the government and civil society frustrated efforts to implement a coordinated Covid-19 relief response. These resentments and discord demonstrate that while restrictions and lockdowns may work well enough in the Global North, the benefits may not outweigh the costs in places with contested histories, mistrust of authority, and contempt or neglect for vulnerable populations.

3.6 Towards Grassroots Solutions: Pathways to Food Agency and Justice Beyond the Pandemic

Widespread food insecurity has been a pervasive problem for South Africa's urban dwellers long before the pandemic arrived, as evidenced by the multitude of studies focused on the issue (Ledger, 2016; Crush & Tawodzera, 2016; Jonah & May, 2020). The pandemic lockdowns merely exacerbated an already-existing, long-standing crisis, placing pressure on a structurally weak food system that relied heavily on school feeding schemes for schoolchildren and the informal food sector, causing a systems breakdown and ensuing crisis.

In spite of the double challenge posed by the Covid-19 pandemic and the government-imposed lockdown, community-based and grassroots organizations were able to identify solutions and act on the community's needs. A collective of civil society organizations endorsed by over 200 groups, which emerged in March 2020, formed the Covid-19 People's Coalition, which set forth a call to action on "all people, every stakeholder and sector" in order "to contain infection, reduce transmission and mitigate the social and political impacts of the COVID-19 virus" (C19PC, 2020). It also convened national and provincial issue-based working groups, including food working groups, which took action to respond to the food crisis. As described by a food systems academic participating in the Gauteng province food working group, the organization worked to raise funds to support small-scale urban farmers who were no longer able to access their markets (Interview. Brittany. November 10, 2021). They used funds to buy fresh produce from these farmers and distributed parcels of vegetables to community kitchens and households that had lost their source of income. Food distribution was implemented by community teams on the ground who identified the most vulnerable households, such as those with elderly people or children (Ibid). The working group, which was composed of academics and activists who had previously worked with small-scale farmers, were able to compile a list of farmers available to provide food. Similar to the CANs, the Covid-19 People's Coalition was able to bring resources and people together to connect disparate parts of a fragile community food system. These connections, along with the knowledge and

experience gained on localizing food supply chains, could have long-term implications for building a more sustainable, resilient food system for people in Gauteng.

Many of the lessons synthesized from the CANs, community kitchens, and the People's Coalition can be applied to a sustainable model towards food justice in South Africa beyond the pandemic. As the founder of the community kitchen Ladles of Love noted in an interview, "handing out all the time is also not a good thing" (Interview. Danny. November 5, 2021). Firstly, food justice requires re-politicizing hunger as a societal rather than an individual failure. The stigmatization of receiving food parcels and the shame associated with hunger is well-documented (Paganini et al., 2020; Ledger, 2016). Feeding communities must be continually re-conceptualized as fulfilling a right, not merely keeping someone alive but "nourish[ing] the mind and soul" (Paganini et al., 2021, p. 130). In fulfilling both the right to food and the right to health, people must have access to quality, accessible, and affordable nutritious food, a right that was not fulfilled even before the Covid-19 lockdowns. In order to strive for a more just food system, the pandemic-induced food crisis has shown that the informal food sector, which has often been stigmatized and criminalized (Paganini et al., 2021), needs to be recognized and uplifted as a community-based food system, creating a space to contest and dismantle corporate hegemony of the food sector.

A reckoning with the South African food system begins at the community and grassroots level. The government and the wider global health community can begin with a recognition of invented spaces for food relief, such as the CANs and the Covid-19 People's Coalition food fora, and their work building solidarity networks across different actors in the local food system, linking small producers, fisherfolk, deliverers, community gardens, community kitchens, volunteers and those suffering from food insecurity. By mapping and connecting these components of a community, these grassroots coalitions have built the foundations of resilient and independent locally-based food flows, lighting a tentative pathway towards food agency and justice. However, many initiatives, in particular small community kitchens, have expressed concerns of diminishing donations and lack of self-sustaining measures, forcing some to close or close intermittently (Interviews. Teresa; Chrislyn; Daniel. June to November 2021). Thus, sustainable grassroots solutions require buy-in from donors who can help fund and establish initiatives started during the pandemic,

while giving full autonomy to communities to direct their own programs. For example, as one food systems academic mentioned, the government could set up subsidies to community kitchens and gardens, stipends for people working on food relief responses, and corporate taxation schemes to redistribute some of the profits dominated by large retailers (Interview. Brittany. November 12, 2021). Furthermore, programs building food agency in communities should be combined with a repurposing of communal resources and spaces based on the ideas of community members themselves, righting the wrongs of spatial and geographic discrimination that many informal settlements face.

Food agency and justice can not be achieved without addressing other pervasive issues, such as a lack of economic opportunities, education, housing rights, racial equity, gender equity, political agency, and the injustice of the broader sociopolitical system. In applying a biosocial approach to health, food security is a baseline for fulfilling the right to health, but it remains one aspect of a deeply embedded system. Given that the pandemic has raised awareness of the issue, practitioners must think more holistically about embedding access and sustainability in local food networks, and the collective aid provided in response to the first years of Covid-19 has already begun the work of building back a better system.

CHAPTER 4: INDIA

"They have a lot of skill, knowledge, even resources, not maybe necessarily financial resources, but human resources, knowledge, insight. That can be utilized, so the response would become more effective and less costly."
– Kuldeep, Mentor with Navchetna Sarvangin Vikas Kendra, Grassroots community development NGO

The sheer scale and widespread consequences of Covid-19 infections and lockdowns in India presented an unprecedented challenge for civil society responders. They had especially adverse effects on migrant workers and informal workers, who were often left behind by state policies and faced income loss and stigmatization. Due to its history of community-based decision-making and resource control at the local level, the Indian state of Kerala proved exceptionally prepared for the pandemic's effect on vulnerable populations by providing social safety nets. Meanwhile, NGOs shifted operations to fill in the gaps in the nationwide response, providing meals, essential goods, health services, and care for members of their communities. These responses were

characterized by a holistic approach to healthcare and a propensity for using already-existing resources in an innovative way. Furthermore, grassroots associations, such as the Ideal Youth for Revolutionary Change (IYRC) based in a migrant community in New Delhi, were best able to identify the specific needs of migrant workers, often related to difficulties accessing state resources, and set up interventions in order to address these gaps. While perhaps not as cohesive and politically potent as the CANs in South Africa, civil societies and community-based governments in India represented key actors in mitigating the negative consequences of the pandemic.

4.1 National Covid-19 Response in India: The World's Largest Lockdown

The first Covid-19 case reported in India on January 30th was the first of three cases of students returning from Wuhan, China (Patel, 2020; Rawat, 2020). Forty-one days later, the number of cases had risen to 50. As community spread became more frequent, cities and states began implementing frequent testing and quarantine measures. The most consequential act occurred when the national government declared a thorough pan-India lockdown starting March 24th, 2020 with little warning. The lockdown was later extended to May 3rd. These acts elicited similar praise as South Africa's stringent lockdown: WHO Representative to India Henk Bekedam called the initial lockdown "comprehensive and robust," while the United Nations News tweeted that "United Nations stands in solidarity with India in its fight against COVID-19" shortly after the first lockdown began (Press Trust of India, 2020).

Data demonstrates that India's lockdowns proved more far-reaching and stringent than those of most other countries around the world. Oxford University's Government Response Tracker scored India as a 97 on its Stringency Index, which runs on a scale from 0 to 100 (Patel, 2020; Hale, Webster, et al., 2020). Literature written about the beginning of the national lockdown confirm its gravity. Under the national policy of "geographic quarantining," localities with high numbers of cases were "earmarked and subjected to stringent lockdowns with policing and close monitoring by health officials" (Patel, 2020, p. 267; Patranabis et al., 2020). The first lockdown also halted international and domestic

flights and stopped all public transportation (Venkata-Subramani & Roman, 2020). Only travel for essential goods and services provided at hospitals, pharmacies, and grocery stores was allowed. Police forces were tasked with enforcing the rules, while group tracing on mobile apps and video surveillance were leveraged to monitor and enforce social distancing. Unfortunately, despite these emergency measures, the first lockdown failed to quickly "flatten the curve" of case numbers. The lockdown was extended in April 2020 due to the rising case load, which had surpassed 10,000 reported cases (Venkata-Subramani & Roman, 2020).

Figure 3: Trajectory of India's Covid-19 Lockdowns in 2020

Phase name	Dates	Major restriction or relaxations
Phase 0 (Prelockdown)	1–24 March 2020 (24 days)	No restriction; all activities in business-as-usual mode
Phase 1	25 March–14 April 2020 (21 days)	All transport, industrial establishment, commercial and private establishments, and hospitality services closed
Phase 2	15 April–3 May 2020 (19 days)	Allowed: Farming operation, some industries, movement of cargo
Phase 3	4–17 May 2020 (14 days)	Cities are classified into three zones (Red, Orange, and Green). Relaxation of rules in the Green and Orange zones. Allowed: Activities permitted during Phase 2 and construction activities and movement of vehicles for selected activities permitted. Restrictions similar to Phase 1 applied in the Red zones
Phase 4	18–31 May 2020 (14 days)	Allowed: Movement of vehicles without any special conditions along with the opening of the industry.

(Goel et al., 2021)

While case loads began steadily decreasing in September 2020 and remained relatively contained into the beginning of 2021, by March 2021, it was clear that cases were rising dangerously again (JHU CSSE, 2021). The second wave of Covid-19 cases proved much more devastating and deadly than the first. Characterized by the strong spread of the more contagious SARS-CoV-2 sub-lineage B.1.617.2 or "Delta" variant, the second wave of Covid-19 cases led to shortages of oxygen and hospital beds and more deaths among younger populations (Asrani et al., 2021). According to a news report, by late May 2021, around 27 million infections had been confirmed in India and over 300,000 people had died, although experts say these figures likely understate the actual death toll (The New York Times, 2021). With global media attention trained on a crisis devastating one of the largest and most populous countries in the world, people everywhere looked on in horror

as oxygen supplies and medicines dwindled, people died untreated in hospital parking lots, and the demand for cremation services skyrocketed (Gettleman, 2021; Frayer, 2021). Critics blamed Prime Minister Narendra Modi's premature declaration of victory over the pandemic as a catalyst for the calamitous second wave, as evidenced by news articles written at the time (Frayer, 2021). When political leadership let down their guards and removed restrictions, people gathered at election rallies and holiday celebrations without face coverings (Narayan, 2021).

Despite this calamity, the Covid-19 crisis played out on a backdrop of India's unique legacy of public health interventions and federalist governance. Its experience with emergency responses to natural disasters and diseases, along with its concerted efforts to decentralize and build healthcare capacity, led to its pandemic preparedness in 2020, particularly at the grassroots and community levels. In the following sections, I explore India's model of decentralized health governance as an alternative development path and show how this legacy shaped the robust Covid-19 response at the community level.

4.2 A Legacy of Holistic and Decentralized Health: The Case of Kerala

The path of development has always been contested in post-colonial India, as described in Ranjita Mohanty's chapter of Osaghae et al.'s (2010) book on *Citizenship and Social Movements*. The benefits of economic growth from the industrialization and production of goods, though meant to reverse poverty and promote equity, often benefited elite groups of Indian society to the exclusion of "the poor, the landless, low castes and tribal communities that had suffered social and economic vulnerability in the past" (Mohanty, 2010, p. 241). Thus, people began to challenge and resist the state-sponsored vision of development in the 1970s, criticizing the way public goods of national growth had become private goods benefitting only a few. Many grassroots movements protested the centralized governance of economic growth and resources, which they claimed further marginalized the voices of the poor. While many of the prominent grassroots health or local public health initiatives launched in India do not necessarily constitute broad social movements, they remain in the spirit of challenging the neoliberal development agenda

dominant in the 1980s and 1990s. They reclaimed "people's freedom to choose development on their own terms" (Mohanty, 2010, p. 248), identifying the needs of their communities, centering the needs of the poor, and allocating resources accordingly.

The quintessential experiment of decentralized health governance took place in Kerala, India, as a response to the rise of privatized healthcare and the limited public sector resources divided between all Indian states. In the 1980s, the National Health Policy encouraged privatized care through neoliberal cost-benefit rationales, so that over a period of fifteen years, the private sector had grown to manage 80% of ambulatory care and 60% of inpatient care across the country (PHCPI, 2015). Unsatisfied with the decreasing accessibility of healthcare in the state, in 1996, the People's Campaign for Decentralized Planning led the state government to decentralize and reallocate much of its power to village governments or *panchayats*, as written about extensively in the literature and news media alike (PHCPI, 2015; Elamon et al., 2004; Raghunandan, 2020). Although part of a general strategy of decentralization across India, implemented by the central government itself, the state of Kerala's implementing authorities seem to have taken the process more seriously and undergone the most extreme changes out of all the Indian states (Chathukulam & Tharamangalam, 2021).

Under the reformed system in Kerala, primary health care (PHC) centers and their referring sub-centers were managed by village governance, to build direct trust and communication within their communities for more efficient and responsive health initiatives (PHCPI, 2015). Community members were able to come together and determine their health priorities, ranging from improving PHC facilities to enhancing water and sanitation systems. This community-led prioritization also allowed physicians and healthcare workers to engage deeply with citizens, which improved facilities according to the communities' will and simultaneously encouraged lower socioeconomic groups to utilize public health centers. Though difficult to capture all the dimensions of the impact of Kerala's decentralized system, the reforms appear to have long-term benefits. In 2011, the state had achieved the highest inequality-adjusted Human Development Index out of all of India's states, well above the national average, with comparatively low infant and maternal mortality (PHCPI, 2015; Planning Commission, 2011).

More recently, the "Kerala model" has paid off twofold during the Covid-19 pandemic (Chathukulam & Tharamangalam, 2021). Kerala's relatively robust and responsive institutions of governance and public health gave it an advantage in successfully responding to the Covid-19 case load spikes. The infrastructure for state provision of essential services and social security were already in place, and its public health care system was free and accessible to all Keralans. Furthermore, because of the embeddedness of public participation and social mobilization, intertwined with the state's commitment to inclusivity and equity, the synergies between state and civil society give Kerala an advantage in effectively implementing crisis aid and response on the ground. Its policies promoting panchayat funding and decision-making rival those of other states which often bypass or underfund local governments (Raghunandan, 2020). Prior to the pandemic, the financial leeway that panchayats had in Kerala allowed them to implement social programs such as food programs for the poor and day care for the mentally and physically disabled. These safety nets and assistance programs allowed for mobilization of existing resources to answer the surge in demand for relief and care work during the lockdowns. This advantage was clearer early on during the initial outbreaks of Covid-19 in India. While resources were still strained during the third wave of Covid-19 outbreaks, during which the state failed to contain the outbreak, its public trust and institutional competence based on democratic principles allowed it to implement stronger pandemic containment and mitigation policies overall, especially as compared with other Indian states (Chathukulam & Tharamangalam, 2021).

4.3 Migrant and Informal Workers: Who is Locked Down?

Due to preexisting landscapes of class and caste difference, income inequality, and spatial discrimination, the lockdowns did not have the same effect across all segments of Indian society. In particular, the plight of the migrant laborer was well-documented by domestic and global news articles and academic articles. Of the estimated 100 million internal migrant workers in India, close to 90% faced a loss or reduction in income (Jesline et al., 2021, p. 3; Deshingkar & Akter, 2009, p. 28). As an unrecognized category in most Indian states, migrant workers "were left with no mechanisms to access basic needs or seek

redressal for non-payment of dues" after the announcement of the first lockdown (Rao et al., 2020). Many of these migrant workers earn low-income daily wages, live in substandard and unhygienic living conditions with a lack of basic amenities, and have little access to economic or social support from the government (Jesline et al., 2021). As verified by several papers, the sudden announcement of the lockdown and the suspension of trains and public transportation led to scenes of migrants walking hundreds of miles, deprived of support and options, making the journey home by foot (Purushothaman & Moolakkattu, 2021; Shome, 2021; Rao, 2020). Many journalists and academics have documented the inhumane hardships faced by the migrants in the exodus, including starvation, thirst, illness, lack of shelter, lack of access to healthcare, lack of care for children and the elderly who made the trip, mental health issues such as depression and anxiety, and heart-rending stories of women giving birth along the side of the road (Purushothaman & Moolakkattu, 2021; Shome, 2021; Jesline et al., 2021; Rao, 2021; The Indian Express, 2020).

As with the case of South Africa, the national lockdown exacerbated already-existing inequalities and neglect of marginalized groups whose human and socioeconomic rights were deemed less valuable or less crucial than others. Shome (2021) problematizes the way the Indian state perceived some groups as "saveable" and able to be protected by the lockdown, while others fell outside of the framework of "saveability" and securitization (p. 319). Social distancing and stay at home orders were meant to keep everyone safe from Covid-19, but in reality, migrant workers were far more susceptible to increased dangers on their lives and livelihoods than middle and upper income groups in India (Shome, 2021). Instead of waiting a few weeks or days to begin the lockdown, allowing migrant workers to return to their families, the government chose to disregard the burden on migrants in favor of an immediate response, which would protect and prioritize the upper and middle classes, who could be locked down quickly with less threat to survival. Similarly, ordering people to shelter at home in one place has less practical meaning for those without a permanent home or whose home is constantly shifting, as is the case with many migrant workers in India. Migrant workers often live in a space of tension between home and homeless-ness, of mobility and immobility, rendering it a challenge to simply stay at home. Shome (2021) labels these discriminations against migrant workers the "unequal

temporalities" and the "politics of im/mobility[1]" through which the lockdowns played out (p. 325-331).

Notably, several articles mentioned the exception of Kerala, which had several institutional mechanisms in place to provide aid and relief to migrant workers under lockdown. Kerala, though not a dense metropolitan site like New Delhi or Mumbai, is categorized as a destination state, where migrants from lower income states go to seek urban economic opportunities (Rao et al., 2020). During the lockdown, migrant laborers were recognized by the state of Kerala as "guest workers," allowing the state to proactively provide humanitarian aid, including setting up camps, distributing food through community kitchens, providing free rations, and paying pensioners (Purushothaman & Moolakkattu, 2021, p. 6). It also exerted pressure on the Indian government and fellow state governments to follow its example (Purushothaman & Moolakkattu, 2021, p. 6). In their evaluation of social policy regarding migrant workers during the Covid-19 crisis, Rao et al. (2020) noted that Kerala was "the only state where all workers interviewed received both state and employer support" (p. 1653) and "the only state that had arrangements for the healthcare of migrant workers" (p. 1651).

Other non-migrant informal workers also faced disproportionate burdens when the lockdown was announced. Global and domestic media have documented the job loss, food insecurity, and lack of support that domestic workers, taxi drivers, and street vendors in India faced (Ravi and IndiaSpend.com, 2021; Shaikh, 2021; Sen, 2021; Patel and Shah, 2021). In my interviews with SEEDS India representatives, the NGO staff suggested that many lower-middle-class informal laborers suffered the most, as there were social aid systems that reached the poorest, but working class people were too proud or preferred not to ask for help (Interviews. Parag and Yezdani. September and October 2021). As demonstrated by Rao et al. (2020), gaps in the coverage of state social protection were filled by civil society organizations and migrant support networks, where such groups "stepped in as the state transferred the responsibility of care to employers, communities and the civil society" (p. 1656). In the upcoming section, I examine some of these relief

[1] Here the author uses the forward slash in the term "im/mobility" to represent the non-binary, fluid nature of mobility and immobility (Shome, 2021).

efforts and show why the localized, ground-up approach from NGOs succeeded in alleviating some of the burden of those most affected by the lockdowns.

4.4 Designing a Whole-of-Health Community-Based Response

The grassroots Covid-19 response in India was characterized by leveraging pre-existing resources to respond to the new needs of the pandemic. Large and small NGOs and CBOs across India have created innovative programs addressing the holistic nature of the problems exacerbated by Covid-19. Many have addressed issues from food insecurity to healthcare capacity building, often meant to reach the most under-resourced or last mile populations in India. Beyond civil society, empowered panchayats as a grassroots institution, particularly in Kerala, also played a key role in disseminating information, building trust, and coordinating care systems among their constituencies, according to news articles profiling the role of panchayats (Manor, 2020; Raghunandan, 2020). It is at the intersection of civil society efforts from the national to the local level that created a whole-of-health social safety net for the vulnerable and ultimately saved lives, even amidst the initial shock of the first wave and the overwhelming morbidity of the second. In particular, grassroots efforts demonstrated the ability of marginalized communities to exercise agency in identifying and responding to their own needs.

4.4.1 Essential Goods: Ration and Sanitation Kits

Upon the implementation of the first lockdown, which resulted in widespread income and job loss, food insecurity and hunger became a number one priority concern for many households. According to an article in *Ideas for India*, children lost access to regular mid-day meals through schools and childcare centers (Dreze & Somanchi, 2021), while over 50% of workers reported reducing their meals to once a day in one Indian state, as reported in an ActionAid rapid assessment (ActionAid, 2020). Relief efforts from the national government attempted to address this crisis through food rations distribution, employment programs, and cash transfers, although they were limited and unreliable,

making up only a fraction of the loss of income many households faced (Dreze & Somanchi, 2021).

In response, many community-based and grassroots efforts came together to provide food relief to the poor and working class. One interviewee from SEEDS (Sustainable Environment and Ecological Development Society) India described it as "everyone's effort" across government and NGOs (Interview. Parag. October 6, 2021). SEEDS, a humanitarian disaster relief NGO that operates across India, was met with the unique challenge of responding to a global pandemic rather than a localized natural disaster. To fill the gaps of the government's feeding schemes, SEEDS coordinated the distribution of dry ration kits, designed with nutritional value in mind, so that households, particularly those with children and elderly people, could obtain food and water (Ibid; SEEDS India, 2020). They also distributed sanitation kits with basic sanitation goods, including masks, toothbrushes, toothpastes, feminine hygiene products, and sanitizers (Interviews. Yezdani and Parag. September 20, 2021.) SEEDS India attempted to "reach different communities," tapping into their networks of "partners, volunteers, and district administration" (Ibid). Due to the nature of the lockdown and self-isolation rules, the majority of the on-the-ground, physical work was done by SEEDS' partners and pools of volunteers based in communities across India. As Yezdani and Parag noted, only "10-15% of the work" was done by SEEDS headquarters; the rest was carried out by volunteers (Ibid).

Swasth Foundation, a non-profit health social enterprise based in Mumbai, also coordinated distributions of dry ration kits of about 15.5 lakh meals or two to four weeks' worth of supplies (Swasth Foundation, 2021). In order to complement the government's rice-based ration kits, the Swasth Foundation kits included wheats, pulses, oils, turmeric, and other spices. The food was distributed through a safe and efficient volunteer-led model, leveraging Swasth's pre-existing warehouses normally used to store medicines and medical equipment (Interview. Garima. November 19, 2021). Similar to SEEDS, Swasth relied heavily on its teams of active volunteers and leaders in the community to distribute the food, maximizing time and cost efficiency. Local police personnel, community leaders, schools, and NGOs provided support by disseminating knowledge about food distributions to their networks and communities, ensuring that the ration kits reached over 50,000 people.

Meanwhile, smaller grassroots efforts also sprung up or scaled up in order to meet the rise in demand for food, water, and essential goods. According to an *Interface* journal article, Deccan Development Society is a collective of Dalit women farmers working towards food sovereignty and sustainability, using "traditional seeds, organic methods, local knowledge, and cooperation" (Kothari, 2020, p. 6). Dalit women face discrimination at the intersection of caste and gender in India's caste-driven and patriarchal society, but through grassroots organizing, they have reclaimed some power and agency in centering indigenous knowledge. The organization donated 20,000 kilograms of foodgrains towards Covid-19 relief, and they fed 1000 glasses of millet porridge every day to municipal health workers and local police officers during lockdown (Ibid). A *Globe and Mail* article profiled Khaana Chahiye, a local food drive in Mumbai that worked with 18 partner organizations and 100 volunteers on the ground to distribute meals and supplies to people living in slums three times a day during the second lockdown (Bhatt & Walsh, 2021). Collectively, the mosaic of food relief efforts across India paints a picture of an active and responsive network of civil society actors drawing attention to the unequal burden the Covid-19 crisis and lockdowns have placed on migrant workers, informal workers, slum dwellers, rural villagers, and other marginalized groups. This network, indispensable in delivering the basic necessities of food, water, and essential goods to their communities, would become equally important in meeting the healthcare demand and filling in the gaps of the healthcare system in the direst period of the pandemic in India.

4.4.2 Access to Healthcare: Leveraging Community Clinics and Building Emergency Capacity

Although NGOs and CBOs were quick to address issues of food insecurity and access to basic goods, most also moved beyond these needs to take into account whole-of-health responses to the various emergencies different segments of the population were facing. My findings showcase organizations that addressed access to healthcare, access to medicines, information dissemination, employment, education, childcare, mental health, donations of personal protective equipment (PPE) kits and oxygen to healthcare facilities, Covid-19 vaccine access, and healthcare capacity enhancement. Here, the legacy of holistic,

decentralized health and past NGO efforts to ensure healthcare for all played a role in civil society's capacity to mobilize quickly and efficiently to address health shortages.

During the second surge of Covid-19 cases, India's health system experienced a critical shortage of oxygen concentrators, needed to save the lives of many who had been infected by Covid-19 (Guenot, 2021). Having never undergone a surge in demand, India was unprepared, with limited domestic capacity for manufacturing oxygen concentrators, creating a rise in price up to nine or ten times their original value (Mathew & Jayakumar, 2021; Guenot, 2021). In response, SEEDS India established a program to support government health facilities by providing oxygen, PPE, and sanitizer to healthcare providers (Interview. Yezdani and Parag. September 20, 2021). Through the program, it also enhanced healthcare capacity through activities like installing oxygen units in hospitals. Most notably, the NGO helped fill a critical public information gap by setting up a community helpline to provide minute-to-minute information on where oxygen cylinders could be found. With a handful of different oxygen cylinder vendors in the community, healthcare providers and ordinary citizens found it difficult to know at any given moment which vendor might have cylinders in stock and which ones were sold out. By implementing an in-house team of partners and volunteers that operated the helpline, contacted the vendors, and updated the information constantly, SEEDS delivered access to life-saving information to the community. Its current focus, a Covid-19 vaccine drive program aimed at reaching the last mile, similarly provides community outreach (Interviews. Yezdani and Parag. September and October 2021). It works across India, searching for people in categories who may face barriers to getting vaccinated, such as remote populations, elderly people, disabled people, migrants without government-issued ID cards, transgender people, and sex workers (Ibid). The NGO offers them transportation to a vaccination center and help in obtaining the vaccine. SEEDS is also currently advocating for government-sponsored walk-in vaccination centers in order to make the process as easy and accessible as possible. This NGO, though usually focused on natural disaster relief, played a crucial role in leveraging volunteer networks and crisis resources in order to fill critical gaps left uncovered in local communities and across India.

Similarly, the community health non-profit Swasth Foundation built its Covid-19 response strategy primarily on leveraging pre-existing resources. Active since 2009, the

organization was able to tap into its network of community health clinics to continue to ensure healthcare delivery to those struggling with a loss of income. With twenty clinics in slums around Mumbai, all well-staffed, stocked with medicines, and offering low-cost alternatives to privatized care, Swasth Foundation provided over 30,000 in-person consultations and over 5,500 teleconsultations between March 2020 and January 2021 (Swasth Foundation, 2021). As highlighted by Garima, an executive trustee at Swasth, the aim was to keep health clinics operating, as the closure of other clinics caused panic and anxiety in the community. By upgrading their safety protocols and training their staff, Swasth clinics were able to continue providing consultations, check-ups, tests, and medicines to patients with fees reduced or removed entirely (Interview. Garima. November 19, 2021). By leveraging pre-existing access to information on suppliers and an independent medical supply chain, the NGO was able to obtain and donate full body suits, N95 respiratory masks, sanitizers, and eye protection to public hospitals, urban health posts, police personnel, sanitation workers, and other NGOs in the community (Swasth Foundation, 2021). The NGO also designed programs according to a holistic approach to health, disseminating Covid-19 information through posters and social media, supporting frontline workers through yoga and wellness sessions, and hosting community workshops to teach parents simple ways to keep children physically and mentally healthy during confinement (Ibid).

Many of Swasth's activities stem from its mission to integrate Western medicine with traditional ayurvedic knowledge on health and well-being. This conceptualization of health development is derived from an indigenous understanding of holistic wellness, challenging hegemonic health development narratives based in Western biomedicine. By centering long-established wellness activities in India, such as performing yoga exercises and incorporating traditional herbs that improve immunity, the Foundation puts forth a post-colonial contestation of global health development, which often insists on targeting one disease or one problem and intervening on one plane of health. Not only is the NGO responsive to the communities' needs and attentive to weaknesses in the local health system, but it also actively inserts grassroots knowledge and traditions into its operations, blending globalization from above with "globalization from below," as expressed by Appadurai (2000). Furthermore, this allows Swasth to move beyond healthcare delivery as a service

to an extension of human connection and cultural values. When prompted to speak on what she was most proud of, Garima stated:

> "I can say for myself…we went back to our values and said, how can each of our values come into action in this period…For example, joy, how can we bring in joy in the smallest of things in such a time of desperation and hopelessness?" (Interview. Garima. November 19, 2021.)

The case of Swasth Foundation illustrates that it is not only important what services or goods are provided during pandemic relief, but how they are provided, distributed, and disseminated amongst the community that respects the dignity of individuals who are subjected to inhumane suffering. This mentality allows Swasth to share ownership in its response with aid receivers, volunteers, and other community-based organizations and extend values of holistic well-being and positivity at a time of declining mental and physical health.

Based on my observations, both SEEDS India and Swasth faced few bureaucratic barriers and government impositions in operating during the lockdowns, working independently in their respective communities. One a nationwide disaster relief non-profit and the other a well-established community health NGO in Mumbai, they were able to continue operations as normal with little resistance from the authorities. When asked, SEEDS India representatives responded that SEEDS worked in tandem with district governments to implement some of their activities, while Swasth supported many frontline government healthcare workers and other municipal personnel through their relief programs (Interviews. Yezdani and Parag; Garima. September and November 2021). The following section contrasts these experiences through an exploration of government neglect through the lens of a less-resourced NGO that operated in a migrant worker community.

4.5 Government-Civil Society Synergies and Negotiations

In a *Time* article profiling the work of NGOs and CBOs in the Covid-19 crisis, some civil society organizations were described as "run by volunteers belonging to minority communities that the government has been antagonistic towards in the past" (Singh, 2021). At a time of rising Hindu nationalism and centralized control under Prime Minister Modi's administration, many activist NGOs and individuals have been labeled as anti-national or terrorist by right-wing politicians and government officials. Tandon and Aravind (2021) decried the backdrop of the state-sanctioned silencing of civil dissent and the crackdown on civic spaces during the Covid-19 relief efforts (p. 1). During the Covid-19 crisis, the Indian state made charges against "human rights activists, student activists, intellectuals and detractors," invoking "sedition and terrorism laws" (Purushothaman & Moolakkattu, 2021, p. 6). The government also used the immobility of the lockdowns and the distraction of the Covid-19 crisis to restrict public consultations on several wide-reaching policies (Tandon & Aravind, 2021, p. 10-12). The Prime Ministers' Citizens Assistance and Relief in Emergency Situations (PM-CARES) Fund, coupled with secretive amendments to the Foreign Contributions Act of 2010, allowed central authorities to gatekeep civil society funds and threatened the already limited resource flows to smaller non-profits (p. 12-13).

The Ideal Youth for Revolutionary Change (IYRC), one such small youth-led non-profit based in the village of Sameer in southwest New Delhi, responded to the financial shortages and lack of social safety nets to the best of its ability (Interview. Pravin and Rahul. November 19, 2021). The village hosts a substantial migrant community, and the NGO is primarily made up of children of garment workers, street vendors, and other low-income informal laborers. Normally an organization focused on building human capital and empowering the community, such as running creative education programs for kids and providing entrepreneurial support to small businesses, the IYRC pivoted operations to deliver dry ration kits and PPE when the first lockdown began. Though under-resourced and underfunded, the NGO was able to leverage pre-existing volunteer and civil society networks to obtain goods and distribute them to those in need. However, the challenge of covering everyone was exacerbated by IYRC staff's frustrations with the government

neglect of migrant communities and its lack of data on migrant workers. As stated by Pravin, a co-leader in operations at IYRC and a child of migrant workers:

> "Because of the lack of the data, the government facilities or health facilities, which has been provided within the community…is disproportionate in comparison to the population." (Interview. Pravin. November 19, 2021).

Thus, the provision of health services is "abysmal" and "not enough" to serve a hugely undercounted population of migrant workers and their families (Ibid). Simultaneously, migrant workers who had lost their salaries due to the nationwide lockdown did not have savings and could not afford basic necessities, let alone medical expenses, exacerbating the health situation in Sameer.

In meeting the challenges of inadequate healthcare and social protection, IYRC was particularly attentive to the needs of the community. The organization set up a helpline and help desk where members of the community could ask for resources and supplies (Interviews. Yezdani and Parag. September and October 2021). It eventually established a migrant support center to help migrants with obtaining ID cards and ration cards and opening bank accounts. Many migrants, upon returning to urban centers to work, could not obtain government-sponsored rations since they were not registered in the areas in which they worked. By going to the government offices to obtain documentation, migrants risked facing long waiting times and extortion. Thus, the migrant support center was created to ease the process and fulfill basic rights promised under India's welfare state. IYRC also receives feedback forms from the community on the quality and types of services migrants would like to have. The NGO analyzes the feedback in weekly team meetings and strategizes on how to be responsive to the community's needs. Like Swasth Foundation, IYRC goes beyond service orientation, centering the empowerment of those they are hoping to help.

Even beyond a people-centered aid system, by highlighting the unique challenges faced by the migrant community in New Delhi, IYRC makes visible what has been invisibilized or swept under the rug by government officials. It moves beyond depoliticized

service delivery and crisis relief to carving a space for migrant workers' lives and voices to be seen and heard. At the end of the interview, Pravin emphasized:

> "This is one thing that…we really want our government to do. We want our government to recognize, at least recognize the population that lives here... We want an inclusive society of financial inclusion, the social inclusion, the cultural inclusion." (Interview. Pravin. November 19, 2021).

Pravin mentioned the upcoming statewide census and how counting migrants would help ensure adequate healthcare and educational services to migrant communities in their destination states. He emphasized the valuable contributions of migrant workers to the economic and developmental growth of the cities and country in which they work and their deserved integration into Indian society. Through the Covid-19 crisis and the accompanying media attention and public sympathy towards the plight of migrant workers, there is renewed hope of transformative change around the root causes of migrant precarity, such as recognition from state and national governments and the accompanying provision of adequate services. Not only are the IYRC and similar NGOs responding to the crisis and meeting an immediate demand for food and healthcare, they are challenging the dominant narratives of government indifference and marginalization. Thus, they are performing advocacy work that goes beyond the crisis at hand and looks to long-term improvements within their communities, given the window of opportunity of public attention on migrant worker issues.

No doubt public emergencies often require both centralized planning and decentralized action, implying a good working relationship between government and civil society. As the trustee from Swasth Foundation proclaimed, an effective response requires a "combination of nimbleness on the ground" and "central planning" since "neither can function on its own" (Interview. Garima. November 19, 2021). Through the examples of civil society organizations that I have examined, each NGO negotiates its own relationship with the national and local governments, and NGOs often operate independently of government input. Some district governments, such as Kerala, have built long-established robust protections for its population and recognized migrant communities, allowing them

to design a more comprehensive and inclusive Covid-19 relief scheme. However, it appears that there could be room for more synergies across civil society networks and with formal governance. Without an overarching coordination system managing the immense civil society relief efforts, there may be duplication of efforts and wasted resources. The national government, rather than trying to silence opponents and control civic spaces, could make a good faith effort to recognize and consult with civil society organizations. More financial resources could have been distributed to community-based organizations, and consultations with the realities on the ground might have better directed resources to those who needed it most. This critique echoes many of the issues between government and civil society in the South Africa case as well. In the next chapter, I will synthesize the lessons learned from both cases and draw upon analysis of key similarities and differences between the two.

CHAPTER 5: SYNTHESIS: LESSONS LEARNED FROM SOUTH AFRICA AND INDIA

5.1 The Pandemics Behind the Pandemic

In the previous two chapters, I have described and highlighted key aspects of the grassroots and community-based responses in South Africa and India. Although the two present very different country contexts, there are many overarching themes and concepts that can be synthesized to demonstrate how public and global health systems can engage grassroots and community-based strategies in the Covid-19 emergency response. Despite the limitations of generalizability of these country case studies, the similarities and themes across the two cases can hold important lessons for health decisionmakers and stakeholders. This chapter aims to set forth comparative observations and comment on how the lessons learned on the ground can shape better global and public health policies moving forward. I reflect on the work of civil society during the pandemic as advocacy work and a form of protest, though not necessarily explicitly or intentionally so. I also argue that civil society work necessarily creates a space for citizen and community participation in health policies and social protection. This kind of invented space can lead to promising new synergies between government and bottom-up NGOs and organizers.

Both country cases revealed, perhaps unsurprisingly, that many underlying inequalities and inadequacies were heightened by the pandemic and ensuing lockdowns, leading to a pandemic of multiple crises. Garima, the representative from Swasth Foundation summarized this point well through her reflection on the lessons learned from the pandemic:

> "For me, the biggest lesson has been that the pandemic and the death and the pain that it caused was a fundamental reflection of people not being in a good state of health." (Interview with Garima. November 19, 2021).

In both countries, there was an aggravation of long-standing neglect and inequality that was previously normalized by governments and society (Dehkordi, 2020; Omotoso & Koch, 2018; Shome, 2021; Purushothaman & Moolakkattu, 2021). Issues such as police brutality, food insecurity, lack of income, lack of adequate standard of living, and lack of access to healthcare, which had previously been held as normal in a state of permanent brutality and inadequacy for the marginalized and the poor, made a dangerous situation even more dire in disadvantaged communities. In South Africa, a fragile corporate-based food system would have collapsed and erased many informal settlers' access to food during the lockdown if community-based organizations had not set up community kitchens and networks of local food delivery. In India, migrant workers who were not registered with their destination countries were denied access to government ration kits and reparations for loss of income. Many of these issues directly impact one's health and well-being, even if they aren't construed under global health governance or biomedicine as healthcare. In this section, I discuss each of these underlying pandemics behind the Covid-19 pandemic in South Africa and India, highlighting how fragile and marginalizing systems worsened the Covid-19 crisis in both countries.

The right to food perhaps played one of the largest yet most overlooked roles in the Covid-19 pandemic for South Africa and India. The problem of hunger has often been constructed as an unavoidable social condition or a matter of charity and humanitarian aid rather than clinical health (Geissler, 2013). As global health practitioners remained fixated on caseloads and hospital capacity during the pandemic, they overlooked the way in which

the shuttering of informal food networks and the sheer loss of income across the poor and working class manifested rampant food insecurity. The efforts of grassroots responders not only helped mitigate the hunger through community kitchens and food parcel distributions, how they fed was informed by the community's nutritional and cultural needs. As many interviewees pointed out, feeding is not simply filling people's stomachs, but a nourishing act taken with attention to people's dignity and agency to access and choose what they consume (Paganini et al., 2021; Interview with Daniel, 2021; Interview with Nicole, Nomonde, and Haidee, 2021). Government food parcels in South Africa did not include perishable foods, omitting fresh fruits and vegetables, dairy products, and meats vital to a well-balanced diet, all products which were initially unattainable in informal settlements due to the closure of spaza shops and street vendors (Paganini et al., 2021). Community kitchens realized this discrepancy and strove to deliver these missing components to their communities despite the major logistical challenges and rising prices (Interview with Teresa, 2021; Interview with Chrislyn and Marlene, 2021). This case calls for a reevaluation of what is considered essential or nonessential by national governments and how consultations with the grassroots can lead to more informed decision-making on what businesses to close and what to leave open.

In both countries, loss of livelihood from the lockdowns limited people's access to housing, food, clean water, sanitary living conditions, and healthcare. In the case of South Africa, a lack of social safety nets for informal workers and large-scale unemployment in shantytowns meant that these communities had little choice but to rely on community-based organizations for support. The networks of Covid-19 relief solidarity arose out of necessity to build the infrastructure of social protection to save lives, an infrastructure that did not previously exist. In the case of India, the government eventually provided ration kit programs and a guaranteed employment scheme for rural residents. However, migrant workers inevitably slipped through the cracks of the social safety net, as they were not a recognized group in many destination states and went uncounted by government censuses (Paliath, 2021; Jesline et al., 2021). They could not access ration kits and other protections if not registered where they lived. Furthermore, the sudden announcement of the first lockdown left many migrant workers completely stranded with no transportation and few options to access basic necessities or seek redress for employers who withheld salaries or

refused to pay (Rao et al., 2020; Shome, 2021). The lack of will to hold factories and other employers of migrant workers accountable shows a level of disregard for the interconnectedness of the labor system and the health system. These employers, as primary sources of income for entire populations, should have constituted a priority concern for the Indian government and been held responsible for the treatment of their workers during lockdown.

Finally, the pandemic also exposed holes and weaknesses in health systems, which are often under resourced at the primary health care level and fail to cover all sectors of society equally. The prevalence of chronic diseases such as HIV/AIDS and tuberculosis in both country cases heighten the risk for serious illness or comorbidity from Covid-19. However, the closure of community health clinics and the sparse availability of affordable health clinics to low-income populations to begin with suppressed access to health even further (WHO, 2021; Vyas et al., 2021; Mehlwana, 2020). Loss of income meant many households living hand-to-mouth could scarcely afford food, let alone medical consultations and necessary medicines. The privatization of healthcare and the inadequacy of free public healthcare, coupled with the fear and anxiety spurred by the Covid-19 lockdowns, rendered basic checkups and medical treatment an unaffordable expense in the middle of a pandemic. Furthermore, there was little consideration of how to mitigate the onslaught of serious mental health consequences as people were faced with anxiety, depression, anger, fear, grief, loss of loved ones, loss of social support systems, and uncertainty about the future (Maben & Bridges, 2020; Kim, 2020; Nguse & Wassenaar, 2021; Choudhari, 2020; Venugopal et al., 2020). Without the psychosocial consideration of many civil society organizations in South Africa and India, which aimed to relieve some of these anxieties through compassionate and thoughtful care, an infrastructure of professional mental health support would be completely absent.

The use of stringent lockdowns as a security measure demands the question of whose security and at whose expense. At a time of global outcry against police brutality around the world, centralized governments were quick to mobilize police forces and even military forces to contain the virus and maintain compliance to lockdown rules (Amnesty International, 2020; Kalkman, 2020; Staunton et al., 2020; Egwu, 2021; Purushothaman & Moolakkattu, 2021). By narrowly construing the pandemic as the Covid-19 virus and its

morbidities, both the South African and Indian governments failed to take into account all the underlying crises that would be heightened by a stringent lockdown. This point is not to advocate for the government to stop all top-down measures or even to discontinue lockdowns, but it highlights the importance of consulting with people on the ground and ensuring adequate safety nets for all segments of society. Barring extensive consideration and protection for all those affected by such measures, a lockdown order cruelly condemns many under-resourced communities to suffer from hunger, thirst, homelessness, and illness, all with potentially graver consequences than contracting the Covid-19 virus. At the global health systems level, issues of food insecurity, loss of income, access to clean water, and access to adequate housing should be priority concerns, given the same weight and consideration as Covid-19 transmission itself.

5.2 Top-Down and Bottom-Up Conflicts and Negotiations

Although the joining together of centralized top-down policies and decentralized bottom-up interventions can create cause for conflict, both are needed to meet the difficult demands of a widespread emergency. In the following section, I explore different aspects of top-down and bottom-up contestations and synergies in both South Africa and India. Then, I provide some normative reflections on how these two approaches to crisis management might better work together towards a mutually reinforcing response while acknowledging the significant challenges to cooperation, particularly in the case of South Africa.

Conflict and negotiation between civil society and national government manifested in different ways depending on the local contexts and the identities of those challenging the status quo. As gleaned from my South Africa case study, the constant push and pull of government-sanctioned lockdown restrictions and civil society operations actually empowered and legitimized many grassroots efforts. The history of government inaction with regards to the plight of informal settlements (Dehkordi, 2020) and the distrust fostered by endemic corruption (Bruce 2014; Cotterill, 2022) allowed the community action networks to gain prominence as primary crisis responders in South Africa's provinces. They gained legitimacy on the ground as actors who held the best interests of their

communities at the heart of their work, and the egalitarian power-sharing structures that the CANs formed put political gain aside to center human relationships and human needs (Cape Town CANs, 2020). Though explicitly removed from the South African political party system, the formation of the CANs can be seen as a radical act of protest, as they strive towards a vision of competence, public trust, good governance, and people-centered care that many hope to one day see reflected in formal governments.

The case of India, on the other hand, presents a case of sometimes strained but mutually reinforcing relations between government and civil society. While the two often worked independently of each other, each implementing their own programs, one at the national level and the other at the community level, civil society often took the initiative to complement or reach out to national public health systems in order to provide them with support. Both SEEDS India and Swasth Foundation worked to donate PPE, beds, and oxygen supply to public hospitals. Swasth Foundation aimed to serve government health workers with mental health and wellness programming. At the local level, Swasth Foundation also partnered with municipal bodies, such as local police and schools, to distribute food ration kits. Navchetna, a rural-based NGO, worked closely with gram panchayats and ASHAs[2] (community health workers) to distribute ration kits and hygiene kits and provide free transportation to hospitals and clinics (Interview with Kuldeep. November 30, 2021). The representative from Navechtna reported strong collaboration among local stakeholders in order to establish community trust and leverage each other's resources.

In both cases, increased coordination between the grassroots and the national top-down efforts could result in an overall more efficient and successful system of aid delivery. There is a need for governments to recognize the work and sociopolitical significance of civil society and plan policies under full consultation with community representatives, including CBOs and NGOs, rather than expecting civil society to compliantly follow the lead of national Covid-19 relief efforts. All grassroots and community-based organizations interviewed in this thesis reported a lack of resources to cover everyone in their respective communities, threatening the sustainability of their Covid-19 programs. Although donors

[2] ASHAs are community health workers under the Accredited Social Health Activists program, launched in India in 2005 as part of its National Rural Health Mission to improve rural service delivery, community engagement, and health program ownership (Scott et al., 2019).

and governments should work to ensure accountability and appropriate use of funds during an emergency, some leniency and removal of bureaucratic barriers to quickly support and sustain life-saving efforts on the ground would be welcome. The Covid-19 pandemic calls for a reimagining of accountability mechanisms, perhaps relying on different checks or on networks of peers to legitimize an organization's activities during times of crisis.

5.3 Consulting the Grassroots: Fostering Democracy and Empowering Grassroots and Civic Responses in a Crisis

Given the enormity of the work required of civil society during the Covid-19 crisis and its significant role as an advocate for the poor and the marginalized, there is much more scope for support and coordination between the top-down and bottom-up levels. In particular, resource-wealthy organizations or governments can ensure more resources are funneled towards impactful work done by grassroots organizations. Beyond a need for resource and logistical support, recognizing community-based and grassroots organizers as crucial stakeholders and policymakers in an emergency response is the first step towards more inclusive crisis planning. In the following section, I outline four key aspects to rethinking and uplifting on-the-ground actors and how they contribute to a more efficient and equitable crisis response.

5.3.1 Formal and Informal Civic Participation

In both South Africa and India's civil society responses, there was a divide between well-established, registered NGOs organized by systems of hierarchical bureaucracies and more informally-led organizations, often under-resourced and not registered with the government, and therefore unable to access state-sponsored resources. This was prominent in the example of community kitchens in South Africa's informal settlements, which were at odds with lockdown restrictions since they had not obtained formal permission to operate, yet some were feeding and ensuring the survival of hundreds of people per day. In India, many long-established organizations with formal partnerships, and in many cases corporate,

philanthropic and government sponsorship, were easily able to continue operations and garner support among other local organizations. However, small, unregistered CBOs and NGOs, which were often grassroots organizations embedded within their communities, lacked this support and permission to operate. This was the case with Chrislyn's Harmony's Angels community kitchens and the Heather Anne Project in Vrygrond and with Ideal Youth for Revolutionary Changes (IYRC) in the migrant community of Sameer, New Delhi (Interview with Chrislyn & Marlene, 2021; Interview with Pravin & Rahul, 2021). Both reported difficulty in navigating government bureaucracies for financial support and continuing operations day-to-day with limited resources.

There is a need to recognize and resource all segments of civil society as on-the-ground policymakers in an emergency. They are the ones deciding how to obtain food and supplies, where to distribute them, how to allocate limited resources, how to disseminate information to the public, and how to ultimately provide care and services to their communities. Most notably, these decisions reflect the will and needs of the community better than top-down policies, and in the particular case of the CANs, made without any formal leaders or hierarchies of command. These organizations are also crucial in encouraging civic participation and community engagement. Most of the work was carried out by volunteers on the ground, even volunteers at more formalized, bureaucratized organizations like SEEDS India and Swasth Foundation. Specialized NGOs like IYRC and Navchetna were key players in bringing youth, women, and lower caste involvement to the Covid-19 crisis response, with strong implications for placing inclusiveness at the heart of public health decision-making. As important as top-down crisis management is in providing direction and leveraging centralized power to obtain resources, there is a need for more consultation at the grassroots, for the incorporation of formal and informal civic voices in emergency response planning, and ultimately for a blended response of centrally-controlled and flexible, decentralized programs and activities.

To begin to achieve this, consultations at the grassroots level should happen on mutually agreed-upon terms, which respect the unique character of community-based and grassroots operations, even if that means experimenting with more creative ways to engage with these organizations. For example, the horizontal and flexible nature of governance and organization within the Community Action Networks in South Africa meant there were

no designated "representatives" that municipal or national governments could meet with. One article written by a group of researchers closely involved in the CANs reflects on this challenge:

> "The experience of the CANs hints at the potential of a reimagined community health system in which the false binary between community and state is challenged, and the power of informal networks and collective action in unprecedented crisis situations is brought to the fore. But it has also brought into sharp focus the emergent tensions and complexities at this interface, even in the context of genuine commitment to engage from both communities and the formal health system" (van Ryneveld et al., 2020).

Ultimately, the innate formalization and bureaucratization of government and its accountability mechanisms (i.e. formally registering with the government as a non-profit organization, obtaining permits to operate, writing impact reports to justify allocation of financial resources) makes it a challenge for spontaneous networks like the CANs and the grassroots organizations that make up the CANs to meaningfully engage with top-down governance and donors. This quandary points to a need for the government to be able to step outside their bureaucratic frameworks and meet civil society collectives on their terms. Officials should come to the field, visit community kitchens, interview people involved in the CANs, conduct research on grassroots responses in the community, and hopefully realize ways to increase recognition and support of their work outside of complex and formalized procedures, where the onus is too often on civil society organizations to prove their worthiness.

5.3.2 Solidarity Networks, Coordination, and Collaboration

The unprecedented scale of challenges brought forth by the Covid-19 pandemic also ushered forth unprecedented networks of coordination and solidarity amongst civil society groups. The Cape Town Together network brought together 170 community action groups and thousands of volunteers (Cape Town CANs, 2020; Cape Town Together, 2020).

In many ways, these connections allowed less resourced groups to access the finances, knowledge, and networks of more prominent or resourced organizations, reducing the barriers for informal actors to participate in the Covid-19 relief response and producing an inclusive and equalizing effect. In its Covid-19 relief activities, Amava Oluntu reported assisting other community kitchens to obtain food and navigate government and donor-imposed bureaucratic hurdles. A representative from Muiz Kitchen and a participant in the Muizenberg CAN, Michael, confirmed that since registering as a Public Benefit Organisation (PBO) with the government was too much of a hassle, Amava Oluntu allowed Muiz Kitchen to use its PBO number and provided formal administrative support to the kitchen (Interview. Michael. November 11, 2021). While perhaps legally murky, this kind of support allowed a humble community kitchen to concentrate its efforts on feeding people during an emergency rather than navigating bureaucratic paperwork.

In a similar manner, the Swasth Foundation in Mumbai, India was able to bridge an information gap between itself and other NGOs in the area responding to the crisis. At a time of great strain on supply chains of PPE and oxygen concentrators, Swasth was able to leverage its FDA-approved drug warehouse and its own pre-existing independent supply chain and contacts to procure these items for relief activities (Interview. Garima. November 19, 2021). It then supplied and donated these materials, which were difficult to obtain at the time, to other healthcare facilities, frontline workers, nonprofits, and local organizations. Many of these nonprofits lacked access to contacts and insider information in order to know how to procure these essential items, which allowed Swasth Foundation to step in and bridge the gap. At the same time, interviewees expressed a need for further coordination and sustained coordination throughout a long emergency like the Covid-19 pandemic.

> "I feel like in terms of organizing actually local ecosystems at a community level, there could've been a lot more collaboration between organizations." (Interview. Garima. November, 19, 2021).

Garima mentioned having a centralized hub for food distribution or one designated center for telehealth across various clinics to avoid duplication of efforts.

In Cape Town, Manya, a healthy systems academic and a CAN participant, noted that the CAN had inquired about using local community halls, public spaces, or schools that weren't being utilized due to lockdown in order to create self-isolation centers (Interview. Manya. December 1, 2021). At the time, South Africa had a contract with a multinational hotel management corporation to provide a self-isolation center that provided a bed and three meals per day and was available and free to the public (Engen, 2020; The President Hotel, 2021). However, people had to physically travel, sometimes over several kilometers, in order to reach an government-sponsored isolation center, and many did not have the means to protect their homes or leave their households for the quarantine period of two weeks (Interview with Manya, 2021). Thus, setting up community self-isolation centers, where meals could be provided by community kitchens, would have been useful for many people in informal settlements. Furthermore, it would have freed the enormous amount of government resources spent on a program, one that benefitted the private sector, for more community-based and public health-based interventions. However, this CAN-inspired isolation center project was never realized due to government resistance around the CAN's request for resources (PPE and beds) and the lack of mechanisms in the government bureaucracy for distribution of such resources to the community. A contract with the community was deemed too problematic and complex. This failed attempt presents a case of a missed opportunity for coordination and collaboration between civil society and the public sector as well as a failure to make public spaces and resources truly public and accessible to the community. It points to the way formalized and bureaucratized public health and emergency responses turn away from the community in favor of the private sector. It also brings the justification of cost-effectiveness into question, as involving the community would not have only made the self-isolation centers more efficient and inexpensive, they would have also provided innumerable benefits to the community in the form of accessibility, solidarity building, and potential future use as community shelters.

5.3.3 Innovation at the Grassroots

The work of civil society in the two country case studies also necessitates an acknowledgement of the imaginative, creative, and positive ways in which civil society

developed programs and strategies to provide Covid-19 relief. With the need for immediate action and eyes and ears on the ground, they were able to quickly assess what would work and what wouldn't work in the community. Civil society activity demonstrated that delivering food en masse, mobilizing PPE, or disseminating important public health information could be accomplished without a top-down directive and with the resources at hand. Perhaps most notably, they showed that food can be made free and accessible for all at a low cost, although the viability of such initiatives heavily depended on the sustainability of funding and resources.

My case studies reinforce the OECD report "COVID-19 innovation in low and middle-income countries," which detail how Covid-19 responders "reengineered resource use across critical processes" and developed activities or programs that were not only "user-centred" but "user-led" (Ramalingam & Kumpf, 2021, p. 16-17). Examples can be found in Swasth Foundation's repurposing of its medical storage buildings for food parcel distribution and venues for small community talks or workshops on dealing with the pandemic. The IYRC, made up of youth from migrant communities near New Delhi, developed a migrant resource center that provided the kind of support and services they would like to see for themselves and their families. One program that looked towards long-term sustainability was the food for work program run by the nonprofit Navchetna Sarvangin Vikas Kendra (NSVK) in Maharashtra, India. Seeing the rampant unemployment among the rural landless caste, Navchetna promised villagers food for work they could perform in their own villages. Many worked on developing community water resources, digging, cleaning, and renovating ponds for a reliable source of clean water. The benefits of this work could then be reaped by the community in the long term.

The case studies also reveal innovation beyond the programs themselves to how ordinary people and civil society can creatively come together, organize, manage, and implement community initiatives. The CANs in South Africa remain a remarkable feat of innovation at the grassroots, a responsive and inspiring force that rallied people of all different segments of South African society together around a single purpose: to alleviate the suffering from Covid-19 in their communities. The use of temporary nodes of action around one project or program, which formed and disbanded as needed, reflected a novel way of advocacy and organizing that has further implications for public participation and

civil society action. The lack of a bureaucratic or hierarchical structure within the CANs along with the overlapping activities and nature of the CANs themselves, could be interpreted as a radical and innovative way to achieve true equity and democracy in power-sharing and decision-making.

Covid-19 spurred many kinds of innovation at the community and grassroots levels. It forced actors to rethink urban and rural innovation and reconsider the inequalities faced by people's neighbors and others in the community. It spurred civil society to investigate how communities can leverage existing resources to make society more equitable and challenge what situations are considered "normal" and what can actually be changed or achieved with enough will, resources, resourcefulness, and leadership. While sustainability of these projects remains an issue for many NGOs with few resources or that are operating outside of their usual activities, they present areas for further development to build community resilience, prepare for the next pandemic or crisis, and address the abundance of pre-existing and underlying problems all through low-cost, effective, and community-led innovations.

5.3.4 Public Relations

Finally, the role of civil society at the interface of scientific health information and public relations can not be understated. Many interviewees in both case studies reported an atmosphere of fear and confusion when their respective national lockdowns were announced. In particular interviewees from India, a country which contains a larger and more varied population and experienced a more stringent lockdown, reported rampant misinformation, anxiety, and stigmatization of individuals infected with Covid-19. Furthermore, people in both countries were dealing with extreme hardships such as income loss, food insecurity, housing insecurity, immobility or forced mobility, and loss of loved ones, which all contributed to feelings of fear, isolation, grief, and hopelessness (Nguse & Wassenaar, 2021; Jesline et al., 2021). During this time of worsened emotional and psychological states, it was important to have grassroots and community-based groups step in to fill information gaps and perform the care work necessary to alleviate the collective trauma of an entire population.

Grassroots organizations are most able to identify the kinds of information that would be useful and crucial to the community. To be sure, public health messaging directed at the individual, such as teaching people the proper way to wear a mask or changing handwashing behavior, was important to prevent the spread of the Covid-19 virus. However, beyond telling people to wash their hands several times a day or physically distance over and over again, often in informal settlements and urban settings where such attention to hygiene might be close to impossible, community-based NGOs worked to inform people where to obtain free food parcels or cooked meals and which vendors had oxygen cylinders available (Interview with Garima, 2021; Interview with Parag, 2021). Community workshops focused on dispelling unfounded rumors about the disease or focusing on boosting health holistically also helped put a familiar human face to public health information. Garima, the representative from Swasth Foundation, noted that Facebook posts focused on positive messaging to improve well-being received a more positive response than Swasth's posts repeating standard government information. Community-based groups translated knowledge from the language of public health and science to the vernacular, as well as translating information into the local languages. Thus, they are building and leveraging community trust, often stronger than people's trust in the government, and wielding it to quell panic, overcome the spread of misinformation, and check in on people's well-being in a dark time.

5.4 Pandemic Citizenship and Grassroots Activism: Re-Politicizing Global Health

Both the cases of South Africa and India demonstrate that civil society and citizen volunteers from the community participate and become important policymakers or practitioners in their own right, especially in the midst of a public emergency. They fill in the gaps where governments can not move quickly and efficiently enough. They advocate for the marginalized, who often face adversities policymakers can fail to consider when imposing restrictions. They move "at the speed of trust," making an effort to establish close relationships and legitimacy with partners and the community itself. They are arguably more important than political leaders, upper-level civil servants, public health leaders,

heads of organizations, and other high-level practitioners, policymakers, and technocrats in the way they influence what happens directly on the ground and as the faces of Covid-19 relief. All citizens under a global pandemic, whether from the Global North or the Global South, deserve to have their basic rights fulfilled and an equitable representation of their voices reflected in public health planning and response, as promised by international norms and national constitutions. The importance of inclusivity can not be overstated.

There is also a need for spaces of deep reflection on the Covid pandemic and response and what it has shown, lessons learned, ways to prepare for the next crisis, and most importantly, addressing the underlying issues. Social determinants of disease that have been depoliticized and normalized, such as food and housing insecurity, have been sidelined by governments and global health practitioners for too long. The Covid-19 crisis offers a chance to reexamine existing structures of inequality and re-politicize these issues. The people and organizations most positioned with the credibility and experience to re-politicize these issues are those suffering from a lack of support, the poor and the marginalized at the grassroots. Informal settlers and the urban poor, particularly in large cities like Cape Town or Mumbai, are already key players in politicizing these issues and raising their voices against inequality. The process of re-politicization what has been de-politicized by political and global elites is a transformative act, one that illustrates the power of globalization from below (Hunsmann, 2016; Appadurai, 2000). The fields of global health and public health have also contributed to this de-politicization. While there has been acknowledgement of food insecurity or unemployment as social determinants of health, global health generally remains constricted within the bounds of clinical health and Western biomedicine. Much of global health investment is funneled towards clinical research work and vertical interventions targeting certain illnesses and diseases, with little regard to the stark inequalities, hunger, and poverties their beneficiaries face (Geissler, 2013). This is a form of de-politicizing the major aspects of health as experienced at the grassroots, including poverty and discrimination, compounded by inadequate social protection and infrastructure.

Thus, the efforts of the grassroots and the community-based during the Covid-19 pandemic and lockdowns marks a need for a shift away from top-down thinking and looking entirely to large global health institutions or global philanthropy to lead pandemic

responses. Consultation and support at the grassroots level is necessary to save lives and promote an ethical and just pandemic response. Furthermore, the onus should not be on bottom-up organizations to seek support at the top or speak the language of NGO-ization and formal development. In fact, the global health community should consider pulling back from relying too much on relief responses among global philanthropy and international health organizations. These global governance institutions tend to bureaucratize and develop hierarchies that are non-inclusive and difficult to navigate from the perspective of bottom-up groups. Programs led by major transnational organizations can be too inflexible and too tunnel visioned for the needs of a community during a crisis. Thus, there needs to be a paradigm shift in the way top-down organizations and bottom-up organizations develop relationships and communicate with each other, as there is so often a complete disconnect between these two spheres of global health.

CHAPTER 6: CONCLUSION

As the cases of South Africa and India have shown, top-down, command-and-control policies often fail to respect human rights during an emergency response. Given the need to move quickly to contain the spread of the Covid-19 virus, a lack of transparency and harsh lockdowns took away civil liberties, made it more difficult for civil society to operate, and removed accountability measures for law enforcement at a time when they were being deployed in greater numbers. Such national lockdowns also left many gaps in ensuring health and security for all, failing to reach many marginalized communities and ensure the fulfillment of basic rights. The question that arises proves challenging to answer: Given the nature of a virulent pandemic, is there an alternative model to the top-down national lockdowns of Covid-19, and how could one be implemented?

While a public health crisis demands some centralized coordination, as shown by cases like the US and Brazil during which leaders failed to act, a combination of national policies alongside bottom-up initiatives best responds to the needs that arise during an emergency. Grassroots and community-based organizations communicated directly with their beneficiaries, centered their needs, and filled in the gaps of the national response even under resource constraints. The responses of the bottom-up in South Africa and India displayed principles of rights-based inclusivity, innovation, cooperation, and trust-building at an unprecedented scale. The successes of grassroots and community responses to Covid-19 present an opportunity for public systems, health and otherwise, to increase civic

engagement and draw on the lessons learned among civil society. Reflecting on the dimensions examined in the case studies, public and global health systems can do more to consult with the bottom-up, listen to the bottom-up, support their ideas and initiatives, finance their initiatives, and remove bureaucratic barriers to engagement and funding.

This research project calls on health systems not only to incorporate the buzzwords of "grassroots health" and "community health" into their vocabularies, but to make a genuine effort to integrate civil society and grassroots participation into health planning and crisis response. Governments should value and legitimize invented spaces of civic engagement without co-opting their activities. Such a partnership entails meeting civil society actors on their terms, rather than insisting that they navigate the language and methods of bureaucracy and development. Through this process of empowerment, global health and public health practitioners should also refrain from over-romanticizing what the grassroots can accomplish. Bottom-up initiatives should take careful consideration of the diversity of actors involved, the impact of projects on different communities, and attention to details. Underlying problems such as racial discrimination and unjust food systems will take more than one community-based NGO or grassroots movement to dismantle. Furthermore, health systems should not over-burden unpaid and under-paid community work. Instead, perhaps governments could set up financial pipelines to these collectives and organizations to ensure compensation, although it should be done in a way that respects their autonomy and flexibility.

The underlying factors aggravating vulnerability to the pandemic and the lack of social safety nets to mitigate these negative consequences also point to a need for a paradigm shift to consider the fulfillment of food, water, housing, environment, sanitation, and educational rights as major components of a crisis response. As noted by Jenna Wortham in the New York Times podcast and Garima in my interviews, some people are always unwell and in a state of poor health due to the societal structures that keep them from a state of well-being. This notion applies especially to marginalized communities in unequal societies, like in South Africa and India. Global health cannot continue to be defined under the limited confines of clinical health, but there needs to be a genuine recognition that food security, access to clean water, and housing security are global health issues, not simply humanitarian aid issues. A global health intervention that prevents

infection or addresses an emerging infectious disease is not complete without such holistic approaches to health; anything less would be unethical. Food, water, shelter, and employment create the baselines for health, and they should not be left out of the cost-benefit calculus when tackling an epidemic or pandemic. Global health, which has been increasingly framed around securitization, should be reminded of its original promise to fulfill a rights-based health, linked to a comprehensive and mutually reinforcing fulfillment of all socioeconomic rights.

In the spirit of inclusive development, there is also a need for more participation in tackling pervasive issues and for more inclusive research on these topics. When asking what is public in global health, it is clear that large philanthropic foundations, multilateral organizations, and development banks have more sway on global health than the public in the Global South. Global health is not public enough. The co-research methodology, present in Paganini et al.'s (2021) work, presents an opportunity to include "the researched" in the process of producing knowledge, "to talk with them, not about them and not without them" (Paganini et al., 2021, p. 122). Much like grassroots activism, grassroots sense-making can be just as valuable to advancing more inclusive global health and international development narratives, highlighting the agency of the researched and weighing different kinds of knowledge equally. My own research would have benefitted greatly not only from an in-person field study but from further embeddedness in response activities and a stronger recognition of those who participated in my interviews as co-researchers, making sense of what happened and what is happening alongside me. Inclusive research methodologies are not enough to address all the exclusivities and inequalities present in development research, but it presents a place to begin.

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