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Effects of COVID-19 Lockdown Restrictions among Community Members of Vhembe District in Limpopo Province

Azwinndini Gladys Mudau [1,*], Bumani Solomon Manganye [1,*], Shonisani Elizabeth Tshivhase [1], Ntsieni Stella Mashau [1], Takalani Grace Tshitangano [1], Hlekani Vanessa Mbhatsani [2], Selekane Motadi [2], Brenda Baloyi [2], Anzani Mugware [2], Zwivhuya Patience Mudau [2], Rachel Lebese [1] and Lindelani Fhumudzani Mushaphi [2]

[1] Department of Public Health, Faculty of Health Sciences, University of Venda, Thohoyandou 0950, South Africa; shonisani.tshivhase@univen.ac.za (S.E.T.); ntsieni.mashau@univen.ac.za (N.S.M.); takalani.tshitangano@univen.ac.za (T.G.T.); rachel.lebese@univen.ac.za (R.L.)

[2] Department of Nutrition, Faculty of Health Sciences, University of Venda, Thohoyandou 0950, South Africa; vanessa.mbhatsani@univen.ac.za (H.V.M.); selekane.motadi@univen.ac.za (S.M.); brenda.baloyi@univen.ac.za (B.B.); anzani.mugware@univen.ac.za (A.M.); zwivhuyapatience889@gmail.com (Z.P.M.); Lindelani.mushaphi@univen.ac.za (L.F.M.)

* Correspondence: azwinndini.mudau@univen.ac.za (A.G.M.); bumani.manganye@univen.ac.za (B.S.M.)

Abstract: The mental well-being of many community members was seriously impacted by COVID-19, with some experiencing the loss of loved ones and others losing jobs due to lockdown-related company cutbacks. There is evidence indicating that many people faced challenges in accessing essential services, including healthcare. This study aimed at investigating the effects of COVID-19 lockdown restrictions among community members of the Vhembe District, in Limpopo Province, South Africa. A qualitative, exploratory design was used for this study. Data were collected from 54 participants through nine focus group interviews with six participants each. This study identified two main themes originating from data analysis: community mental health during COVID-19 lockdown, lockdown regulations, and challenges encountered. The participants discussed the impact of COVID-19 during lockdown. This research underscores the vital necessity of implementing harm reduction strategies and long-term service policies for this group. It also emphasizes the importance of equity, diversity, and inclusion in upholding the rights of marginalized populations.

Keywords: effects of COVID-19; mental health well-being; lockdown restrictions; challenges; marginalized populations

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1. Introduction and Background

The COVID-19 was first discovered as originating from the Wuhan seafood market (Surmiak 2020). COVID-19 can spread if a person touches a surface or object with the virus on it and then touches his or her mouth, nose, or eyes, and can be contracted if one inhales air with droplets from an infected person. An individual infected with COVID-19 can spread it when talking, coughing, or sneezing if not wearing a mask (Wang 2020). People with a compromised immune system due to chronic conditions such as hypertension, cardiovascular disease, asthma, and diabetes are most at risk of contracting the virus. Most elderly people are also at risk of this virus since most of them are on chronic medication and have compromised immunity. Most people who have COVID-19 generally present with mild symptoms that can be treated without the need for hospitalization (WHO) (2020a). Clinical manifestations of the COVID-19 disease may appear 2 to 14 days after exposure. Common signs and symptoms can include fever, cough, and tiredness. In a study conducted by the Centers for Disease Control and Prevention (CDC) COVID-19 response

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team, among infected healthcare workers, 66% were found with muscles aches, headache (65%), and the absence of smell or taste (16%) (WHO 2020a).

On 30 January 2020, the WHO declared the SARS-CoV-2 outbreak a Public Health Emergency of International Concern when more than 80,000 confirmed cases had been reported worldwide. Twelve countries, namely, the United States of America, India, Brazil, Russian Federation, France, Spain, the United Kingdom, Italy, Argentina, Columbia, Mexico, and Germany, have contributed more than 66% of the total confirmed cases, globally with the first four worst affected (Mangal and Gupta 2020).

In Hubei province, China, people were subject to mandatory quarantine for up to 14 days (Rothe et al. 2020). On 11 March 2020, the WHO declared the novel coronavirus (COVID-19) outbreak a global pandemic (Rothe et al. 2020). By 27 September 2020, the WHO reported over thirty-two million (32,000,000) confirmed cases of COVID-19 worldwide, with over nine hundred and ninety thousand (990,000) deaths, resulting in a case fatality rate of 3.1% (Ashinyo et al. 2020). A study conducted in the United Kingdom revealed that inequalities in treatment during the COVID-19 outbreak negatively impacted people, particularly those from BAME (Black, Asian, or minority ethnicity in the UK) backgrounds, who faced a higher risk of morbidity, mortality, and poor mental health outcomes during the pandemic (Breakwell and Fino 2021). In March 2020, in South Korea, which was one of the epicenters of COVID-19, there were more than 7000 patients in the area and even confirmed patients were not hospitalized. Among 9000 patients with COVID-19 in South Korea, 158 patients died during the first wave (Minyoung 2020). Italy was among the countries with the highest death toll records during the first wave of the COVID-19 pandemic. A study conducted on the Peruvian population found that 76.9% of people believed that the authorities were not prepared to face the disease, and 62.7% thought that the response of the authorities was not effective (Ashinyo et al. 2020).

A rapid survey of businesses in Uganda suggested that lockdown measures reduced business activity by more than half and found that micro- and small enterprises experienced a larger decline in activity compared to medium and large enterprises (Lakuma and Sunday 2020). The same study's survey data collected in Senegal, Mali, and Burkina Faso suggested that, on average, by the end of April, one out of four workers had lost their jobs, and one out of two workers had experienced a decline in earnings. Some people were found not to have complied with measures of the lockdown due to loss of income, especially in unregistered businesses. This shows that although there were measures that authorities put in place to prevent the spread of COVID-19, people were unable to comply due to fear of loss of income, especially in African developing countries (Statistics South Africa 2020). In March 2020, the South African government declared a national state of disaster and took drastic pandemic-related prevention measures called lockdown. Lockdown measures included a ban on in-person contact; compulsory social distancing; orders to stay at home; quarantine; and temporary closing of all nonessential services, such as schools, universities, restaurants, and retail outlets. In addition, the lockdown measures included the closing of childcare services and primary, secondary, and higher education institutions. During lockdown, many international students were left stranded and vulnerable when students were forced to go back to their respective homes, experiencing challenges in their network, and data arose showing some students failed to continue studying through online platforms.

According to Tisane (2020), some women have a greater chance of surviving COVID-19 than they do of surviving domestic violence. Against this background, there is a clear indication that while the government was busy focusing on business and restriction on people's movement, there was an increase in the number of domestic violence (Tisane 2020).

There are a limited number of studies examining family experiences during the COVID-19 lockdown period, indicating a need to address gaps in the existing literature. The SA Crime Statistics (2021) report documented a significant increase in instances of sexual and physical violence, as well as deaths, during the lockdown. These distressing incidents underscore the urgency of further research in understanding the impact of the lockdown

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on families and the prevalence of GBV during this period. The study that was conducted by the local NGO further attests that more than 500 cases were reported to the local police station during the 2020/21 COVID-19 lockdown period (WHO 2020b).

The WHO (2020b) indicated that globally, as of 4:59pm Central European Summer Time, 1 April 2022, there had been a staggering 486 million confirmed infection cases of COVID-19, and more than 6 million people succumbed to the virus. In America, on the same date, the number of confirmed COVID-19 cases was more than 150 million, while in Europe, more than 202 million cases were confirmed. In Southeastern Asia, more than 51 million cases had been confirmed (WHO 2020b). The education sector has been badly impacted by COVID-19 pandemic (Mahaye 2020). According to UNESCO (2020), many countries closed school activities due to the COVID-19 pandemic, with total of 91.4% of registered learners in these countries temporarily forced out of school

Many women sought for shelter during the COVID-19 period, and the most extreme case was to accommodate a grade 12 learner who was staying with an abusive boyfriend (WHO 2020b). The report by SA Crime Stats (2021) indicated that the number of instances of reported violence rose in the period from October to December 2020. The effects of lockdown are so detrimental to families and the community at large as to lead to more harm to physical and mental health, self-harm, family disorientation, drugs and substance abuse, and poverty.

COVID-19 has changed people's lives globally. Communities were threatened by lockdown rules. Societies were struggling, and people lost their jobs and income. During the lockdown restrictions, South Africa's citizens severely struggled with financial difficulties, anxiety, frustration, and isolation (Sibuyi et al. 2024). This study will provide insights into how COVID-19 lockdown measures affected households in the Vhembe District of Limpopo Province. This research addresses the following question: What were the effects of COVID-19 during lockdown in Vhembe District of Limpopo Province? The study findings can be used in policy development for communicable disease intervention strategies and strengthening existing knowledge in health prevention and promotion.

Theoretical Framework

This study adopted intervention mapping theory. The study is guided by intervention mapping (IM) (Bartholomew et al. 2011). The purpose of IM in this study is to provide a framework for effective decision making at each step in intervention planning, implementation, and evaluation (Bartholomew et al. 2011). IM involves a series of six steps, and each step comprises several tasks. The fundamental steps in the IM process are the following: conduct a needs assessment; create matrices of change objectives; select theory-based intervention methods and practical applications; organize methods and applications; address the sustainability of the program; generate an evaluation plan. However, this study focused on the first two steps. To investigate the effects of COVID-19 during lockdown, the researchers conducted a needs assessment based on enabling, predisposing, reinforcing factors. The needs assessment findings were used to determine the purpose and objectives of this study.

2. Materials and Methods

2.1. Study Approach and Design

This study adopted a qualitative approach which was exploratory and descriptive. The approach ensured that participants could narrate how COVID-19 affected them during lockdown in Vhembe District of Limpopo Province. More information was explored and described applying qualitative data collection techniques which ensured depth of the data collected and capturing of participants experiences (Creswell and Poth 2020) Social research explores a certain phenomenon with the primary goal of formulating more specific questions or hypotheses. It is developed to provide information and insight into clinical and practical problems (Burns and Grove 2015).

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2.2. Study Setting

This study was conducted in Limpopo Province. The province has five districts, namely, Vhembe, Mopani, Sekhukhune, Waterberg, and Capricorn. It has 478 health facilities. This number comprises the following: 411 PHC clinics 28 healthcare centers, 30 district hospitals, 5 regional hospitals, 2 special hospitals, and 2 tertiary hospitals. This study was conducted in Vhembe District and focused in the six selected villages which were Nweli, Malavuwe, Mbahe, Tshamavhudzi, Siambe, and Hamuraga. The selection was performed purposefully based on the high number of COVID-19 cases identified in these areas.

2.3. Study Population and Sampling

The population for this study comprised all community members residing in selected villages of Vhembe district. Their ages ranged between 18 and 95. This study adopted non-probability sampling and participants were selected using a convenience technique. Participants who were available during data collection and willing to participate were included in the sample. A sample size of 54 participants was chosen.

2.4. Data Collection

Data were collected in the selected villages of Vhembe District of Limpopo Province which were Nweli, Malavuwe, Mbahe, Tshamavhudzi, Siambe, and Hamuraga. The researchers explained the purpose, informed consent, confidentiality and anonymity, principle of autonomy, potential risks, and benefits and that the participation was voluntary, and participants had the right to withdraw at a time, on agreement the participants were given a consent form to sign. Numbers were given to the participants to maintain anonymity. To address confidentiality, information was not shared with outsiders. Data were collected in Tshivenda; all participants were Tshivenda-speaking. A voice recorder was used to record the interviews. Observation and field notes were taken to verify the data, which were later transcribed verbatim. An outside venue was selected to ensure proper spacing and ventilation in line with COVID-19 regulations. Masks were worn and sanitizers provided. An unstructured interview guided by one central question was developed and delivered via one focus group discussion comprising six participants to ensure that it yielded the required findings. This method was chosen because it allowed the researcher to ask additional questions beyond the scope of the interview to gain clarity, which are known as follow-up questions and probing questions. Nine focus group discussions consisting of six participants each were used to collect data with a total of fifty-four participants. Each focus group lasted for 45 to 60 min. Data were collected from January to June 2021.

2.5. Trustworthiness

The trustworthiness of the study findings was ensured through credibility, transferability, dependability, reliability, and conformability. Credibility was achieved through prolonged engagement from pre-data collection to analysis. Member checking and constant checking of data and use of independent coder ensure confirmability and dependability. Transferability was ensured by comprehensively describing the methodology, data collection, data management, and analysis until the report was developed. The researcher revised the analyzed information to assess other angles of data analysis that gave comparable results to ensure dependability. Finally, for conformability, constant revision of the transcripts for quality audits was performed by the principal investigator through listening to recordings repeatedly to ensure that the data collected supported the argument backed by literature consulted through scoping review upon discussion of findings and repeatability (Denzin and Lincoln 2018).

2.6. Data Management and Analysis

An audiotape was used to record the interview, and data were checked for audibility and completeness. Confidentiality was maintained by not including participants' names

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on the interview guide. Data collected will not be made available to any person other than the those authorized by the researcher and will be kept in a locked storeroom.

Qualitative data were transcribed verbatim and thereafter translated from Tshivenda to English by the language expert. Tesch's eight steps, as described by Creswell (2013), were employed during data analysis: The researcher read all the verbatim transcriptions repeatedly to give the segment data meaning. All outcomes were written down. All topics with the same meaning were combined and grouped under the same theme. The researcher re-read the transcript and repeated the analysis. The researcher started to code and abbreviate the topics. The researcher developed themes and sub-themes from the transcriptions. The researchers compared the codes, topics, and themes for duplication and initiated grouping of all themes and sub-themes.

2.7. Ethical Consideration

Ethical clearance was sought from the University of Venda Research ethics committee (REC). Permission to conduct the study was obtained from the selected village's traditional authorities. The researchers explained the purpose, informed consent, confidentiality and anonymity, principle of autonomy, potential risks and benefits, and that the participation is voluntary, and then informed consent was signed by all participants.

3. Results

3.1. Characteristics of Participants

A total of 54 individuals (52 female and 2 male) participated. Table 1: 96.3% females and 3.7% males took part in the focus group discussions. Participants ranged in age from 18 to 95 years, where 32–45.37% of participants were bread winners, while 63% were not; 46.2% participants had a secondary education, followed by 29.6% with tertiary education, 16.6% with primary education, and 7.4% with no formal education.

Table 1. Demographic information of participants in percentage.

Demographic	Frequency	Percent (%)
Age range of respondents in years		
18 to 23	3	6%
24 to 31	7	13%
32 to 45	22	35%
46 to 65	19	31%
67 to 95	3	23%
Total	54	100%
Gender		
Male	2	3.7%
Female	52	96.3%
Total	54	100%
Breadwinner		
Yes	20	37%
No	34	63%
Total	54	100%
Level of education		
No formal education	4	7.4%
Primary education	9	16.6%
Secondary education	25	46.2%
Tertiary education	16	29.6%
Total	54	100%

3.2. Themes and Subthemes

A qualitative data analysis identified two (2) themes and eight (8) sub-themes emerged. Table 2 below outlines the two themes as follows: community members' mental health

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during the COVID-19 lockdown; restrictions, rules, and regulations of COVID-19 lockdown. Participants shared how COVID-19 affected them during the period of lockdown restrictions.

Table 2. Themes and sub-themes.

Main-Themes	Sub-Themes
1. Community members Mental Health during COVID-19 lockdown	• Loss of loved once • Loss of employment • Fear of contacting and spreading the virus • Anxiety, fear of death
2. Restrictions; rules, and regulations of lockdown	• Difficulty finding transportation • Loss of freedom of movement • Interruption in conventional schooling • Food shortage

Theme 1: Community members' Mental Health during COVID-19 lockdown

Participants indicated that COVID-19 came with a lot of pain. They indicated that they were still emotionally disturbed by the situation. During the focus group interviews, participants indicated that COVID-19 had severe and negative effects on their mental health as some lost their loved ones, while others lost their jobs because companies were retrenching employers due to COVID-19 lockdown restrictions. Four sub-themes emerged, and they are as follows: loss of loved ones due to COVID-19 infection, loss of employment, fear of contracting and spreading the virus, and anxiety and fear of death.

Loss of loved ones

Participants indicated that they had lost their children, husbands, and close family members, and many community members died due to the infection. They further alluded that the availability of COVID-19 lockdown restrictions affected their mental health as they were not allowed to view their loved one's corpse for the last time before burial, and they described this as a painful situation where they did not see their loved one for the last time as the coffin was not opened.

Participant 03, Female, 59 years old, FGD 1: "I was not allowed to view my husband or say goodbye to him as they didn't allow us to open the coffin and I'm not sure if the person I buried is the right corpse because I didn't verify it. This was very painful and stressful for me and my family".

Participant 11, Female, 43 years old, FDG 3: "It was stressful for us not to see our relative and they also gave us only three days to conclude the burial rights because they were saying we shouldn't keep the corpse for long at the mortuary, I was personally depressed to organize a funeral in a short time of space".

Again, they mentioned that only family members were allowed to attend the funeral as the number was limited to 50 people. They further cited the issue of extended family, and when they are burying their loved ones, they expect support from extended family members.

Participant 07, Male, 36 years old, FDG 6: "We lost our close relatives, and we were not allowed to attend the funeral or burial because of the COVID-19 restrictions, and this affected our mental health because in our culture we must attend to support our family members, even today I don't believe that my uncle is gone because I didn't attend his funeral".

Loss of Employment

Community members indicated that they had lost their jobs due to the COVID-19 lockdown restrictions as many companies were no longer operating, and others lost their

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productivity and had to reduce the number of workers coming on duty. Other companies were closed as they were not regarded as essential services which included the hotels, liquor stores, and other recreational facilities not falling under those identified as essential services.

Participant 19, Female 28 years old, FDG 2: "I was working at the local tavern and my employer said we must not come to work, and it means that no work no pay, it was difficult because we didn't have money to buy food or take care of our family members. It was a very painful experience to look at my children not having food to eat".

The loss of employment by community members was cited as a difficult and painful situation because their companies did not even give them an Unemployment Insurance Fund (UIF), and they had to live by begging for food from relatives and friends. Even the application process for the UIF was very difficult and they never received it.

Participant 01, Female 36 years old, FDG 1: "Even today I didn't get my UIF, and I have to depend on my mother to buy my family food from her SASSA grant, just imagine two families, mine and hers depending on one grant, that was very painful, and we only bought basic food like mealie meal and relish".

Fear of contracting and spreading the virus

Community members indicated that they were afraid of contracting the virus as they witnessed many people dying due to COVID-19. They cited that they feared contracting the virus from their loved ones who were coming from other provinces as during lockdown there were provinces identified as epicenters. They further indicated that they were even afraid to be intimate with their partners as they feared spreading or contracting the virus during the process.

Participant 06, Female, 38 years old, FDG 3: "When my husband arrived home, I had to tell him to tell him to take off his clothes and take a bath before he could enter the house because that time many people were being infected with COVID-19 and I was afraid of those coming from other provinces".

Participant 09, Female 33 years old, FDG 4: "My husband was very angry at me because I refused to sleep in the same room with him because he was coming from Gauteng province and there were many people infected with COVID-19 there, He also threatened to divorce me but I was afraid to contract the virus, who will take care of the children if we all die? but he understood at the end".

Anxiety and fear of death

Community members cited that they were afraid to die since every day they heard announcements of new deaths in their community. Elderly people were living in fear of death as they were classified as high-risk people due to age and comorbidity. They further cited that were afraid to switch on their televisions as they were always announcing new infections and deaths per province, and they thought they would be next to die as the virus was killing many people globally and in the country.

Participant 12, Female 38 years old, FDG 2: "I never wanted to listen to the radio or watch television as it was depressing me to see people dying and our healthcare practitioners contracting the infection, I had to stay home and never leave to see friends and relatives".

Participant 18, Male 62 years old, FDG 5: "I was more afraid as my peers were dying and they were saying it kills older people, I was more afraid even to go out or let people get into my yard".

Theme 2. Restrictions, rules, and regulations of COVID-19 lockdown

During the COVID-19 pandemic, there were so many regulations, rules, and restrictions that prevented people from doing what they were used to do normally before the virus emerged. Under this theme, four sub-themes were identified: difficulty finding transportation, loss of freedom of movement, interruption in conventional schooling, and food shortage.

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Difficulty finding transportation.

During the first hard COVID-19 lockdown, all transportation was restricted from moving except the essential services vehicles and for staff who were rendering such services. Public transport was only allowed to move in the morning and afternoon, while other vehicles were not permitted to move around as one of the measures to curb the spread of the virus. Furthermore, at night, a curfew was implemented as another way of preventing the movement of people in different places.

Participant 14, Female 47 years old, FDG 3: "My kids are working in Gauteng, and they were not allowed to come and see us even when we were sick, I remember there was a funeral at home and my son couldn't manage to come back because he was not having a permit to move from Gauteng to Limpopo as inter provincial movement was restricted".

Participant 10, Female 25 years old, FDG 6: "Sometimes I would wait at the bus stop for more than 4 h with no transport coming as only few transports were allowed to move, and sometimes when you miss the first taxi in the morning, it means you won't go to the clinic or a place where you were supposed to go".

Loss of freedom of movement

Community members were restricted from moving from one place to the other as they were afraid the infection would spread due to movement. Restrictions were established to restrict people from moving from point A to B, especially interprovincial movement. Community members were not allowed to go out of their homes; they were told to remain locked indoors as a measure to stop the spread of COVID-19.

Participant 09, Female 32 years old, FDG 6: "It was so sad because we were jailed in our homes, we were not allowed to go out of the yard, when you go out, soldiers will come and beat you up and you will never go out again".

Participant 07, Female 38 years old, FDG 2: "I was told not to move out of my yard and I didn't firewood to cook for my family, I had to sneak out to go and fetch firewood at the bush, but I was afraid if they find me out, they will beat me up because they never had mercy if they find you out".

Interruption in conventional schooling

Community members indicated that school attendance was interrupted as many schools were closed during the pandemic. This includes both basic and higher institutions of learning as physical contact was not allowed to prevent the spread of the virus.

Participant 02, Female 44 years old, FDG 1: "Our kids were told not to come to school by their teachers and teaching and learning stopped, children were promoted to the next grades without attending or finishing the syllabus".

Food shortage

Community members cited that during the COVID-19 lockdown restrictions they at times lacked food in their families because shops were not operating normal hours due to the regulations. Even big shops sometimes ran out of stock of certain food and other families went without basic food for weeks.

Participant 19, Female 28 years old, FDG 5: "I had money to buy food, but it was difficult to buy food because you go to the shop, and you come back without getting access to buy the food stuff you wanted".

Participant 10, Female 25 years old, FDG 1: "We didn't have food during the lockdown because only rich people bought food in large quantity and as poor people when we go there, we would find that there no food left on shelves, even the local spaza shops will somethings lack certain food items that we wanted to buy, not that we didn't have money".

4. Discussion

COVID-19 lockdown restrictions resulted in the disruption of social, economic, and healthcare provision in the community (Haleem et al. 2020), and people were bound to stay indoors to curb the spread of the virus. The COVID-19 restrictions brought the global

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economy to a standstill and resulted in millions of people losing their jobs and many people suffering from the stress and pain of starting afresh in looking for a new job (Crayne 2020). The restrictions brought many challenges to community members, as many did not access healthcare services, many jobs were lost due to COVID-19, and many families suffered financial constraints.

During the COVID-19 restrictions, bereavement and grief were found to be negative by community members as they were not allowed to view their loved ones and perform their rituals; however, the study found that different people respond differently to grief, and other family members have created alternatives rituals to cope with the loss of the loved ones. On the contrary, the study also found that there was no difference between the attendance of funerals during the COVID-19 restrictions and prior to the occurrence of the pandemic (Mitima-Verloop et al. 2022).

A study conducted in the United States of America found that only a few participants were able to say goodbye in person and able to attend the funeral during the COVID-19 restrictions. The study found that those who attended the memorial service and funeral physically were reported to have less psychological distress as compared to those who did not attend (Chen 2022). Different cultures require family members to view their loved ones for the last time and bid farewell as it reduces the impact of depression in the communities.

Fear of contracting the virus was experienced by many community members as they were afraid to contract and spread the virus to their family members. Another major factor that contributed to the fear was the stigma that was attached to the COVID-19; this left many people afraid of contracting the virus because many people were dying after contracting the virus (Dodd et al. 2022). When people were afraid of contracting the virus, it might mean that community members did not have the necessary knowledge on precaution measures on how to prevent the spread of COVID-19 infection.

The emergence of COVID-19 and lockdown restrictions had a huge impact on the economy and social activities (Mogaji 2020) as several modes of transportation were restricted, and this caused a shortage of transport as many people wanted to travel, but they could not because there were only few modes of transport actively transporting community members. In other countries, the cost of transport went up due to high demand. When there is no transport in communities, all systems are affected as many community members depend on public transport to access healthcare services and workplace.

The normal way of schooling was disrupted by the coronavirus and left many students not attending classes; however, some were able to attend from home, but this affected both the students and teachers negatively as it caused anxiety and distress which further affected their mental health (Reimers 2022). The future of our children is doomed without education, and many children were condemned without writing exams, and even those who were not competent progressed to the next level.

Food shortage was also a concern during the COVID-19 lockdown restrictions as many families reported physical barriers to access food; there were also economical barriers as community members community members were found to be experiencing food insecurity due to job loss. On the other hand, community members experienced poor access to basic food and others due to lack of agricultural activity during the COVID-19 pandemic (Niles et al. 2020).

5. Limitations

One of the primary limitations of this study is the relatively small and potentially non-representative sample size of the population. This may limit the generalizability of the findings to broader populations. The findings may be specific to the unique context of Vhembe District of Limpopo Province, South Africa, and may not be directly applicable to other Provinces or countries with different healthcare systems, lockdown measures, sociocultural factors, and gender, as more of the study participants were females. Moreover, the level of youth participation, i.e., ages 18–30, was quite low, which can be further explored.

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6. Conclusions

In conclusion, this study highlights the importance and urgent need for strategies and policy development for long-term service provision to this population, as well as the literature on equity, diversity, and inclusion as a foundation for the rights of marginalized populations and groups. Future research directions should focus on the evaluation of intervention strategies/COVID-19 lockdown rules and regulations.

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