Necropolitics and Slow Violence: Revisiting Migrants' Access to Healthcare During the COVID-19 Pandemic in South Africa

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Abstract

Migrants constitute a vulnerable group of individuals. Such vulnerability is pronounced during times of crises such as a pandemic. South Africa recorded its first COVID-19 case on 5 March 2020, and the cases kept on surging, prompting the government to announce a nationwide lockdown on 23 March 2020. The COVID-19 lockdown engendered socio-economic, protection, and health challenges to the entire population but with a unique effect on vulnerable groups such as foreign nationals. This paper examines the health challenges foreign nationals faced in South Africa during the COVID-19 pandemic. Theoretically, the paper uses Achille Mbembe's notion of necropolitics to argue that the exclusion of migrants from accessing healthcare resulted in the manufacture of a population who lived at the margins of society, where living meant continually standing up to face death in their everyday lives (slow violence). Methodologically, the paper draws on a qualitative study conducted during the COVID-19 pandemic, where data were generated through in-depth interviews and document analysis. The paper's key findings are that foreigners faced medical exclusion in accessing healthcare and COVID-19 vaccines, and they also faced a lack of information and language barriers, which negatively impacted their access to healthcare services. The paper concludes that these challenges stem from a lack of political will to adequately include foreigners in health initiatives. The insights of this paper may prove helpful in considering inclusive health initiatives.

Keywords: Migrants, COVID-19, South Africa, necropolitics, slow death, healthcare, medical xenophobia

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INTRODUCTION

This paper considers the challenges faced by foreign nationals trying to access healthcare in South Africa during the COVID-19 pandemic. For a long time, South Africa has been described as a highly xenophobic society that does not place value on non-nationals' human rights (Landau et al., 2005; Landau, 2011; Crush and Tawodzera, 2014). Non-South Africans, particularly Black Africans who live or work in South Africa, endure discrimination from, among others, government officials, citizens, and the police. Such discrimination extends to healthcare, prompting Crush and Tawodzera (2014: 1) to characterize the "negative attitudes and practices of health professionals and employees toward migrants and refugees" as "medical xenophobia." That said, attitudes toward non-nationals vary, and it is worth noting the contribution South Africa, in general, and South African public healthcare in particular, have made to migrants from neighboring countries. Notwithstanding this support, migrants experience medical xenophobia that is "experienced in prejudice evident in ethnic slurs, unwelcome and insensitive comments and discriminatory practices, including denial of treatment" (Zihindula et al., 2017: 458). Several studies reveal the low appetite and limited effort from the South African government to curb xenophobia (Landau, 2011; Vearey, 2013; Crush and Tawodzera, 2014; ISS, 2014). In light of the above, the COVID-19 pandemic arguably laid bare long-standing medical xenophobia and, as we argue, cranked up an already deadly, necropolitical machine.

The pandemic occurred during a time of widespread migration, with over 40 million people globally displaced (Chowdhury and Chakraborty, 2021). South Africa has been a popular destination for many African migrants, especially from Southern African Development Community (SADC) countries (ACMS, 2020). South Africa recorded its first COVID-19 case on 5 March 2020, and 18 days later, cases increased to 402 (Modisenyane et al., 2022). This prompted President Cyril Ramaphosa to announce a national lockdown on 23 March 2020 to help control the spread of the virus and enable the health systems to prepare for the increasing COVID-19 cases (Mukumbang et al., 2020). The lockdown came with measures that negatively affected everyone living in South Africa; however, migrants may have been severely affected due to pre-existing vulnerabilities affecting them (Mukumbang et al., 2020).

At the peak of the pandemic, an estimated 4.2 million foreign migrants were living in South Africa (Garba, 2020). Migrants, refugees, and asylum seekers were especially vulnerable because they often lacked resources to protect themselves, including access to healthcare (Jobson et al., 2021). The pandemic's rapid spread and existing global inequalities made the COVID-19 impact particularly severe (Jobson et al., 2021; Mutekwe, 2022). Existing literature on COVID-19 and access to healthcare in South Africa focused on global health security and immigration governance (Vearey et al., 2020), neglect of African migrants (Ndebele and Sikuza, 2020), migrants and limited access to vaccines (Mushomi et al., 2022), and experiences of migrants during COVID-19 (Jobson et al., 2021; Mutekwe, 2022). This paper aims to contribute to this body of literature by focusing on migrants' experiences of accessing healthcare in

South Africa during the COVID-19 pandemic. To achieve this, this paper is guided by the following objective: to analyze the experiences of foreign nationals in accessing healthcare services during the COVID-19 lockdown in South Africa.

Theoretically, this paper draws on Achille Mbembe's (2003) notion of necropolitics to understand the South African government's management of the COVID-19 pandemic. Drawing on migrants' experiences of accessing healthcare that were characterized by medical exclusion and limited access to information, the paper argues that the limited access to healthcare resulted in the manufacture of a population that lived at the margins of society, where living meant continually being subjected to slow violence in their everyday lives. This was necessitated by the South African government's management of the COVID-19 pandemic, which was marked by a categorization of nationals and non-nationals, and among non-nationals, a further categorization existed of documented and undocumented migrants. These categorizations shaped migrants' access to healthcare and created lives that mattered and those that were disposable. As a result, migrants, especially undocumented ones, had limited access to healthcare, which, we argue, equates to conditions of slow death.

The paper commences with a literature review focusing on the global experiences of migrants in accessing healthcare during COVID-19 and an explanation of the theoretical framework that underpins this paper. Next, the paper unpacks the qualitative methodology that was used to generate data, followed by a presentation, analysis, and discussion of the paper's findings before concluding the paper.

LITERATURE REVIEW

Migrant access to healthcare during COVID-19: A global overview

The literature shows that in some contexts, migrants faced limited access to healthcare services, while in others, they were offered full access to healthcare during the COVID-19 pandemic. In South Korea, undocumented migrants were excluded from government face-mask distribution programs (Santillana, 2021). Similarly, Santillana (2021) observes that many countries in the Middle East region excluded migrants from their COVID-19 health schemes and had either differentiated treatment or refused treatment based on nationality. However, in countries such as Jordan (Santillana, 2021), Saudi Arabia (AlFattani et al., 2021), Portugal (Meer and Villegas, 2020), and the United Kingdom (UK) (Doctors of the World, 2020; Meer and Villegas, 2020), migrants and asylum seekers were provided with full access to public services for the duration of the state of emergency.

Many countries excluded undocumented migrants from vaccination drives in policy or practice, and deep distrust of authorities among some migrant populations caused complications for more inclusive vaccination campaigns. For instance, in Hungary, it was challenging to register for vaccination without proof of legal residence (Parker, 2021). Even though Greece began vaccinating refugees living in camps in early June 2021, after what critics called a slow start, undocumented migrants still

could not access the vaccine registration platform (Parker, 2021). While coronavirus vaccines were free and available to undocumented migrants in the UK, booking an appointment required registration with a general practitioner (GP). However, some GPs refused to register migrants who could not provide proof of address or an identity document (ID) (Parker, 2021). In Italy, undocumented migrants were excluded from its vaccination drive because it used an online platform to register for vaccination; the platform needed people to provide a tax code, which undocumented migrants did not have (Panara, 2021). Malaysia's vaccine program excluded migrants, refugees, stateless people, and those in immigration detention centers until June 2021 (Santillana, 2021).

Unlike the cases above, where migrants were excluded from vaccine drives, some countries, like the United States, the Netherlands, Belgium, and Portugal, made notable strides to include migrants in their vaccine drives. For instance, migrants in Belgium were eligible to get the vaccine, and the Belgian government specified that data collected during the vaccination process would be used for health purposes only (Parker, 2021). In addition, the government deployed mobile vaccination teams and worked with local authorities and civil society groups to reach migrant populations. In Brussels, public transportation to vaccination centers was free (Parker, 2021), thereby facilitating easy movement to vaccination sites.

Migrants also faced challenges related to a lack of access to information and language barriers in accessing healthcare during the COVID-19 crisis. This negatively affected their ability to access information on how to protect themselves from the virus, which in turn affected their health. Solidar (2020) notes that governments did not translate COVID-19 safety measures messages into languages understood by non-nationals, prompting civil society organizations (CSOs) to fill this vacuum. For example, Volunteering Matters in the UK deployed volunteers from its European Union (EU) VOICE project to translate the national safety guidelines into 20 languages for all non-English-speaking UK residents (Solidar, 2020). The UK government and National Health Service (NHS) guidance was published primarily in English, which was inaccessible to non-English-speaking migrants. Doctors of the World (2020) observe that even though some translations of the guidance had been published, the number of languages was limited, and updates to these translations were behind the English guidance. To fill this lacuna, Doctors of the World, the British Red Cross, and several other partners translated the NHS guidance into 60 languages, including some audio versions.

The literature also shows that access to vaccines was a huge challenge for migrants in the Global South. Walker et al. (2021a) argue that a few vaccine programs across Africa clarified whether or how migrants fitted into the rollouts. Zimbabwe had vaccine tourism, which started in March 2021, after President Emmerson Mnangagwa said visitors could be vaccinated if they were willing to pay (Mazingaizo, 2021). While Mauritius managed to vaccinate 55% of its population by July 2021, concerns were raised about including migrants in the rollout plans (Walker et al., 2021b). To access the vaccine in Mauritania, people were required to present a national identity card,

and migrants could use the "Mauritian Premium Visa" program to access the vaccine. However, there was no clarity on access for those with unclear status. In Tunisia, documented migrants technically had access to free emergency care, which included vaccinations, but migrants reported being excluded from healthcare services (Walker et al., 2021b). Libya blocked nearly one million migrants from accessing healthcare due to discrimination, lack of documentation, and growing insecurity in the country (Groupe URD, 2020). This prompted human rights activists to call for healthcare to be made accessible to all people in Libya.

However, some countries in the Global South included foreign migrants in their vaccine plans from the onset. For instance, in Egypt, the national COVID-19 vaccination plans included refugees and asylum seekers registered with the United Nations High Commissioner for Refugees (UNHCR) (Walker et al., 2021b). Rwanda was one of the first 20 countries worldwide to begin vaccinating refugees and asylum seekers alongside citizens as part of the national response plan. In Senegal, refugees were included in the vaccination campaign from the outset. In the Central African Republic, UNHCR succeeded in advocating for the inclusion of refugees in the state's vaccine rollout plans (Walker et al., 2021b). This study seeks to analyze the experiences of migrants in accessing healthcare facilities in South Africa and how necropolitics shaped these experiences.

THEORETICAL FRAMEWORK: NECROPOLITICS AND SLOW VIOLENCE

In understanding the health challenges foreigners faced during the COVID-19 pandemic in South Africa, this paper employs Mbembe's notion of necropolitics. Mbembe (2003) introduced this concept in the context of bio- and necropower that illuminate the insufficiencies of Foucault's (1979) biopolitics in examining current forms of subjugation of life to the power of death. Mbembe built upon Foucault's conception of "biopolitics" but argued that in eliding histories of colonialism, the concept of biopolitics is impoverished (Mayblin et al., 2019). For Mbembe (2003), necropolitics includes the authority to impose social and civil death, and the right to enslave others in other forms of violence. Necropolitics rationalizes death and violence as a way for the sovereign state to sustain its survival. Thus, the exclusion of migrants from accessing healthcare in South Africa is justified through this framework, implying that the sovereign state's exclusion of migrants was clean, quick, rational, and necessary (Masoumi, 2016: 28). Necropolitics concerns itself with social and political power to dictate who and how populations should live or die. Necropolitics is more than the sovereign's power to kill, but to expose other people to death. The exertion of power can take actual control over biological existence or social death, which involves exile or systematic exclusion from opportunities (Torres, 2022).

Mbembe (2003) accounts for seven ways that necropolitics are localized within the state. This study resonates with four of these ways. The first is state terror, where the state exerts power, persecutes, and eliminates certain populations for the sake of reducing political and social contentions toward the state. The second is

the common use of violence, where the state has no willfully shared monopoly on violence but shares it with other actors like policymakers, military, police, criminal justice system, and private and public investments. The third is the "link of enmity," which normalizes the idea that power can be acquired and exercised at the price of another's life with the use of legal and political tools to expand and exert power and punishment over others, through rationalizations of nationalism (Puar, 2007) and assimilation into neoliberal practices that result in violence. The fourth is the differential killing modes like mass killing, drone strikes, and denial of asylum seekers' entry, the invalidation of, and lack of effort put behind supporting those on the margins. This is what Mbembe (2003) calls "small doses" and the exposure to death in daily interactions many marginalized individuals have with "unbounded social, economic, and symbolic violence" that destroys their bodies and social existence. Daily humiliations perpetrated by public forces on certain populations are the strategy of "small massacres" (Mbembe, 2003: 38–39) inflicted day by day, and the absence of basic social goods like housing, money, food, education, and validation of existence. Necropolitics thus persists in the power to manufacture an entire crowd of people who live at the margins of society, where people for whom living means continually standing up to face death in their everyday lived realities (Torres, 2022).

In the context of colonialism, "sovereignty means the capacity to define who matters and who does not, who is disposable and who is not" (Mbembe, 2003: 27), and ultimately, necropower works toward "the creation of death-worlds, new and unique forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of living dead" (2003: 40). Therefore, necropolitics aptly applies to migrants' experiences of accessing healthcare during the COVID-19 pandemic in South Africa. This paper considers how these logics of human hierarchy extend not only to those physically and politically marginalized and subject to very real bodily violence, but also how the state seems to have deployed these same definitions of who matters and who does not in its response to COVID-19. The South African government fulfilled its legal obligations toward migrants to an absolute bare minimum, to the point where migrants, especially undocumented ones, were only prevented from physically dying, though with long-lasting consequences. They were "kept alive but in a state of injury" (Mbembe, 2003: 21). The outcome is a form of slow violence (Nixon, 2011), that is, "violence that occurs gradually and out of sight – an attritional violence that is typically not viewed as violence at all" (Davies and Isakjee, 2019: 214). If necropolitics is, in its most visible form, governing through death, slow violence is both its mode of operation and its effect at the level of the everyday. This paper foregrounds the concept of slow violence to make sense of the extent of the state's harm of migrants, while still meeting its basic human rights commitments.

METHODOLOGY

This paper employed a qualitative methodology through which data were collected from in-depth interviews and document analysis in South Africa, covering the period

between March 2020 and March 2022. The study participants comprised locals who were leaders of CSOs and foreign nationals from countries such as Zimbabwe, Malawi, Mozambique, Cameroon, and Kenya. A total of 16 participants were interviewed — eight females and eight males. In addition, six of these participants were members of either CSOs, 10 were individual foreigners, and four were students. The study employed purposive sampling to locate participants who were either foreign nationals or leaders of CSOs who helped migrants. The sample size was increased through snowball sampling by asking participants to refer the researchers to other potential participants.

Participants were asked to choose the interview medium that best suited them. Eight participants chose Zoom, three chose telephone calls because they did not have either a stable internet connection or a proper information communication technology device, and five preferred WhatsApp audio calls. All interviews ranged from 30 minutes to an hour, and they were conducted in English. An experienced transcriber who signed a confidentiality agreement with the researchers transcribed the interviews. Data were also collected through document analysis of media, CSO or government reports, and academic literature. These various documents were located through a Google search using keywords such as foreigners in South Africa and the COVID-19 pandemic; foreigners in South Africa; and access to the vaccine. Some of the documents used in the study came from participants, especially leaders of CSOs who shared documents that their organizations had developed during the pandemic.

The analysis and collection of data were not separate processes, because interview and document analysis involved endless critical work that pointed to new questions and gaps that were explored through any of the two data collection methods. This was done in a way that, as interviews unfolded, the researchers identified similarities and patterns in participants' storylines and coded them into different themes. Some of these themes presented gaps rather than answers, and the researchers tried to fill these gaps through document analysis and further interviews.

Ethical clearance to conduct the study was granted by the University of Johannesburg, Faculty of Humanities Research Ethics Committee. All participants were informed about the details of the study before they agreed to schedule an interview. The anonymity of participants was guaranteed by using pseudonyms. Before every interview, the researchers solicited participants' consent verbally, and since all interviews were done on Zoom, WhatsApp, or a normal call, voluntary withdrawal could be easily accomplished by simply disconnecting (Lobe, 2017).

PRESENTATION, ANALYSIS, AND DISCUSSION OF FINDINGS

Medical xenophobia during COVID-19 in South Africa

The findings of this paper show that medical exclusion was one of the challenges faced by migrants before the pandemic, and COVID-19 worsened this. Tawodzera (2011: 1) states that "medical xenophobia refers to negative attitudes and practices of

health sector professionals and employees toward migrants and refugees on the job." Medical xenophobia often manifests through the denial of healthcare to migrants. Ndlela (pseudonym), an attorney with SECTION 27 — a South African public interest law center — testified that their organization was overwhelmed with requests from non-nationals who were denied access to healthcare services (Mehlwana, 2021). In a webinar hosted by Maverick Citizen on 17 July 2020, the national chairperson of the Treatment Action Campaign (TAC) — a South African HIV/AIDS activist organization — noted "medical xenophobia" as one of the issues faced by foreigners during the pandemic. She unpacked medical xenophobia as a situation where African foreigners are discriminated against and not assisted at hospitals because they are not South Africans. She added that nurses often vow that, "I would give oxygen to a South African, but not to a non-South African" (Huisman, 2020). Medical xenophobia is not a phenomenon that started during the COVID-19 lockdown, as there is a rich body of literature on it (see, for example, Tawodzera, 2011; Crush and Tawodzera, 2014; Makandwa and Vearey, 2017; Munyaneza and Mhlongo, 2019; Vanyoro, 2019; Mvundura, 2024). This shows that the pandemic exacerbated the phenomenon of medical xenophobia, which resulted in medical practitioners regarding the lives of migrants as disposable and unfit to be cared for, which subjected migrants to slow violence. In this regard, medical xenophobia is an exercise of sovereign power, as nursing personnel exercise the power to choose who will live and who will die; and migrants are often the living dead.

The findings of this paper show that while the South African government's official discourse stated that everyone had access to healthcare, there were administrative barriers that hindered migrants' access. This was evident in the initial COVID-19 testing form, which needed an ID number. In this regard, Mel, a female participant and member of the Lawyers for Human Rights, said they had to lobby against it because it was exclusionary. Similarly, Troy, a community organizer from the Western Cape, narrated that people without South African IDs were denied healthcare services because healthcare workers treated people with IDs better than those without. Troy also narrated an incident where a Cameroonian man had COVID-19 symptoms and called an ambulance, but because of his accent, healthcare workers could tell that he was not a local South African, and the ambulance did not come to his aid. This all points to many forms through which medical xenophobia manifested itself to deny healthcare services to non-nationals through the need for IDs and selective rendering of healthcare services during the pandemic.

However, in some cases, non-nationals did not face challenges in accessing healthcare facilities. For instance, Tariro, a female community organizer on the rural farms of the Western Cape, pointed out that non-nationals were getting help at their local clinic without any problems. This is different from the experiences of medical xenophobia captured above, and this might be because health institutions in rural areas are less bureaucratic compared to those in the city. Tariro also spoke about the use of traditional medicines among non-nationals in her community. She attributed

the use of traditional medicines to cultural beliefs and their strength, compared to the medication that one gets in clinics. She also added that some people resorted to traditional medicines because of the fear of going to a hospital, since many people who went to hospitals contracted COVID-19. Moreover, since medical xenophobia has always been in existence, it might have been their previous experiences of medical xenophobia that prompted the use of traditional medicine among foreign nationals.

Many foreign nationals, both documented and undocumented, who participated in this study accessed healthcare through private healthcare facilities, even though they did not have medical aid. Thus, they paid for their consultations each time they visited a healthcare facility. Their preference for private medical facilities was informed by fear of bad treatment (medical xenophobia) from public hospitals. Eddy, a married man from Malawi who had lost his medical aid after being retrenched during the pandemic, explained that he resorted to private healthcare facilities because public hospitals offer poor service, particularly toward non-nationals. The extract below best captures the poor treatment of non-nationals in public hospitals:

> I do not know if you are aware of it, but we are told that you will not get the best treatment if you are a foreigner and go to government hospitals because you will be the last one to be treated. So, I am not a fan of government hospitals. I would instead take my last money and go to a private doctor (Eddy, interview 2021).

This quote shows that the previous experiences of medical xenophobia had an impact on migrants' decisions to use or avoid public hospitals. This shows that necropolitics has always been in place before the pandemic, which, arguably, means some South African health practitioners have always imposed both social and civil death (Mbembe, 2003) on foreign nationals by denying them access to healthcare. The quotation below adds to the issue of medical xenophobia and the preference for private hospitals captured above:

> There is a former chairperson of the Cameroonian community in the Western Cape who was sick and … went to a public hospital. Though he got an ID, the treatment he received was bad, and he couldn't cope, but luckily, he got some money, and he had to go to a private hospital. He told us we should be very careful. We lost a lot of our people who died because of the situation. So, accessing public health, if you were not a local or did not have the money to go to a private hospital, then you just died. It was scary when somebody said they didn't want to go to the hospital because the treatment was cruel. That is why when I break it down, I would say that is institutional xenophobia, where you call it Afrophobia (Troy, interview 2020).

Terry is among those who accessed healthcare using private healthcare facilities through his medical aid. Terry explained that he once tested positive for COVID-19 in 2020, and he had to use his student medical aid to be tested at the Lancet laboratories. Mary, a leader of an organization called "Zimbabweans in South Africa," reported that she had never seen anyone who had tested positive for COVID-19 in her community. She attributed this to the fact that people in her community were supposed to get tested at a cost, but they did not have the money to do this in the townships, since most people had lost their jobs. For her, this lack of money resulted in Black Africans staying in their homes and not going to hospitals. She added that the ill-treatment of migrants in public hospitals and clinics demotivated them from seeking any form of treatment. The extract below captures her views on bad access to medical facilities:

> For example, when you are a pregnant woman and you get to the hospital while you are in labor, you are expected to pump around R5,000. They don't even consider that there is a child's life that is at stake, and now you are telling me I must pump out that R5,000 before my child is delivered by the doctors. What about hospital bedding? I must pay for all those. Now I'm also at risk of getting COVID, which they're also going to discriminate against me when it comes to the vaccines and all this stuff (Mary, interview 2021).

The findings in this section show that medical xenophobia is not a new phenomenon in South Africa, because it has existed for years (see Munyaneza and Mhlongo, 2019; Vanyoro, 2019; Mvundura, 2024). Moreover, these findings resonate with experiences in Libya (Groupe URD, 2020), South Korea, and Malaysia (Santillana, 2021), where migrants were denied access to healthcare. However, these findings do not align with the experiences of migrants in countries like Jordan (Santillana, 2021), Saudi Arabia (AlFattani et al., 2021), Portugal, and England (Meer and Villegas, 2020), where migrants were given full access to public services during the COVID-19 crisis.

Vaccine rollout and non-nationals

The findings of this paper show that foreign nationals, especially undocumented ones, struggled to access COVID-19 vaccines in South Africa. The South African government began its vaccine rollout program on 17 February 2021 (Walker et al., 2021b). In South Africa, all eligible adults were expected to register on the national Electronic Vaccination Data System (EVDS) that created a national register for COVID-19 vaccinations to assist with the timing, procurement, and rollout of vaccines (Walker et al., 2021b). At the onset of the vaccine rollout, which was when data for this study were collected, the EVDS required either an ID number, passport number, or permit number. Thus, as Vearey et al. (2021) argue, the EVDS had become a barrier for undocumented people living in South Africa to be vaccinated. This resonates with Parker's (2021) observation that in countries where everyone was included in

government programs, administrative barriers blocked migrants from fully enjoying the benefits. This was so because countries that officially included migrants failed to make COVID-19 support accessible, whether through cost, transportation, or language barriers (Balakrishnan, 2021). In the case of South Africa, it failed to devise a means to timeously register undocumented foreigners on the EVDS.

Furthermore, the findings of this paper show that there were contradictory messages from the South African government on the issue of vaccinating undocumented foreigners. The former health minister, Dr Zweli Mkhize, on 30 January 2021 stated that the government had no vaccine plan for undocumented non-nationals. However, on 1 February 2021, President Cyril Ramaphosa announced the inclusion of non-nationals in the vaccine rollout. In addition, on 23 July 2021, the then-acting Health Minister Kubayi stated:

> We have to get guidance in terms of the unregistered [persons] because we are dealing with the government systems and the provision of services. We follow the laws of the country. So, you have to be a documented person in the country. If you are undocumented, it means you are illegal in the country. So, it's a different case. We have a responsibility to those who are known to the state, by the state (cited in Vearey et al., 2021).

Vearey et al. (2021) criticized the minister, asserting that her public statement encouraged negative feelings toward foreigners and went against international public health standards. They also pointed out that it contradicted advice from the African Union Commission (AUC), the International Organization for Migration (IOM), the UNHCR, and the International Labour Organization (ILO), which emphasized the need to include everyone in effective pandemic responses.

On 7 August 2021, the *Saturday Star* cited a Cabinet spokesperson saying that the issue of vaccination for undocumented foreigners had not been discussed before Cabinet, and she was not sure when it would be addressed. In addition, the Department of Health said it was waiting for guidance from the Cabinet on the issue of undocumented migrants (Cloete, 2021). As a result of the delays by the government in devising and implementing a way to register foreign nationals on the EVDS, undocumented people were only able to be vaccinated from October 2021 (*News24*, 2021).

However, the Western Cape Department of Health circular on 29 July 2021 spelled out the procedure for vaccinating undocumented people (Heywood, 2021). Importantly, undocumented persons could register for vaccination using a paper registration form. Additionally, they could respond to the section requiring an ID or passport number with "Undocumented," and provide the rest of the required information in the remaining sections of the form. In Gauteng, undocumented migrants were vaccinated in late 2021 following the partnership between the Gauteng Department of Health, the University of Pretoria, the Johannesburg District Office,

the Anova Health Institute, Médecins Sans Frontières, and the Wits Reproductive Health and HIV Institute (Wits RHI) (Africa News, 2021).

The failure to include foreign nationals in the vaccine rollout plan resonates with experiences from several Latin American countries like Brazil, Mexico, Colombia, and Peru (Bojorquez-Chapela et al., 2024). This has resulted in Bojorquez-Chapela et al. (2024) stating that the COVID-19 pandemic was a test for the policies of inclusion and healthcare for foreigners in most countries. This validates one of Mbembe's (2003) stated ways through which necropolitics is localized within the state through differential killing modes. This act broadly involves mass killing, drone strikes, denial of asylum seekers' entry, invalidation of and lack of effort behind supporting those living on the margins. In this instance, the South African government invested inadequate effort to include foreign nationals in its vaccine drive.

The IOM (2022) notes that some countries avoided publicizing their intentions to include foreign nationals in their vaccination campaigns for various reasons, such as preventing xenophobic reactions. In South Africa, a country that has had several episodes of xenophobic reactions, necropolitics, which rationalizes death and violence as a way for the sovereign state to sustain its survival (Mbembe, 2003), may have been used to avoid xenophobia. The exclusion of migrants from accessing healthcare in South Africa is justified through this framework as rational and necessary for managing populations and ensuring the survival of the state (Masoumi, 2016: 28). This paper's findings on the failure to include migrants in the South African vaccine plan show that this was not unique to South Africa, but that it was a trend in most SADC countries. In this regard, the IOM's (2021) analysis of 15 SADC countries revealed that only three included refugees and asylum seekers in their vaccination strategies, two explicitly excluded them, and the policies of nine countries were ambiguous. Furthermore, six nations incorporated migrants in regular situations into their plans, four excluded them, and five had unclear data. For irregular migrants, four countries excluded them, while data for eight countries remained unclear.

Information, language, and non-nationals during the pandemic

One of the challenges that non-nationals encountered when seeking healthcare services in South Africa was the lack of proper information. Mehlwana (2021) notes that during the first days of the prevalence of COVID-19 in South Africa, there was no form of communication with non-nationals on whether they would be permitted to get tested in government testing centers or not. Such a lack of accurate information may have deterred migrants from accessing healthcare services, assuming that testing centers were meant for locals only. One participant, Mel, stated that CSOs managed to promote access to information on COVID-19 for non-nationals through the Right to Know campaign. CSOs developed information sheets, which were translated into different languages with the help of the Africa Diaspora Forum. Reflecting on this development, Mel remarked that CSOs had done an excellent job that the government

had failed to do. Titoh, a leader of the Makause Community Development Forum, added the following to how his community responded to the pandemic:

> The rise of COVID-19 put us as an organization in a very awkward position, since there was no response or assistance from the government's side or any institution that had to assist; so, we were on our own. So, we established the Makause COVID-19 Campaign on 5 March 2020, before the lockdown was declared, and that is when we were trying to come up with strategies on how we help one another in the fight against this pandemic and what we were facing. We started by creating our leaflet to raise awareness about the pandemic, and then realized that there is more than an awareness-raising campaign needed in the community (Titoh, interview 2021).

Titoh further explained that their leaflet and the awareness campaign were not only about COVID-19 but also about the need for assistance, which was not forthcoming from the state. Zamani, a foreign national from Mozambique, explained that his source of information during the pandemic was mostly the internet. He noted that, besides the videos that circulated of people alleging that vaccines were meant to kill people, he relied on what he was told at work — to always sanitize, wear a mask, and stay at home. He added that some of the information circulating on social media was factual and some was based on opinions, and that it was up to him to choose what to listen to and to do introspection and take whatever was right for him. The information that was circulating was scary, and the quotation below captures how scared Zamani was:

> At one point, I was scared, not knowing which was which, what is it to take, or what is it not to take. I mean, there was a time when I was supposed to go to work, and they said we must stay away from taxis, you know. So, when I was in a taxi and I had someone cough and I thought, "Oh God, here we die." It's based on the mentality and how you take things. But my source of information is primarily from work, because they used to communicate through emails and messages (Zamani, interview 2021).

This finding on the government's failure to ensure access to information corresponds with experiences in various parts of the world. In addition, the issue of CSOs bridging the gap also resonates with the efforts of CSOs in other countries where governments were reluctant to provide information in languages spoken by foreigners. This prompted CSOs like Volunteering Matters in the UK to translate the national safety guidelines into 20 languages for non-English-speaking foreigners (Solidar, 2020).

CONCLUSION

This paper focused on the experiences of foreign nationals in South Africa during the COVID-19 pandemic. The findings indicate that even though the government ultimately devised several measures to ameliorate the effects of COVID-19 on various populations in South Africa, foreign nationals faced challenges in accessing these measures. While one could reason that this was due to the administrative challenges that they faced in registering, the more convincing evidence points to a break in the very design of relief efforts, which were designed without some of the most vulnerable members of society in mind. The paper noted that the tardiness in the state's efforts to include migrants in its COVID-19 health programs can be best understood through Mbembe's (2003) concept of necropolitics, which helps to understand how the South African government rationalized death and violence to sustain its survival. The paper demonstrated that the South African government exerted its power through social death, which involved a systematic exclusion of foreign migrants from healthcare. The paper also found that many of the challenges experienced during the pandemic were not new but had been seriously worsened by the pandemic. For instance, medical xenophobia is an issue that has existed for decades, but the pandemic exacerbated it to the extent that some foreign nationals had to avoid public healthcare facilities during the pandemic, as they feared for their lives and livelihoods. CSOs were found to have played a vital role during the pandemic with little help from the government. This necessitated the need for the government to support and capacitate these organizations financially and to work closely with them in addressing the needs of all who live in South Africa. These lessons could guide smarter, fairer health responses the next time a crisis hits, ensuring that no one gets left behind. Beyond the anticipation of the next pandemic, these insights could guide how the government considers a fairer approach to medical care that helps reverse medical xenophobia before, during, and after a pandemic. This is key, given the rise of anti-immigrant groups-cum-political parties such as Operation Dudula, which block migrants from accessing public health facilities. To turn this tide, the South African government needs political will to address the health needs of both South Africans and non-South Africans resident in the country and to counter the xenophobic tendencies evident in both communities and the government.

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