

No One Is Safe Until Everyone Is Safe

A Study of Migrant Experiences With COVID-19 in South Africa

Research Report

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List of Acronyms

CBO	Community based organisations
COVID	SARS-Cov-2 pandemic
DHA	Department of Home Affairs
DSD	Department of Social Development
EVDS	Electronic vaccination data system
FBO	Faith-based organisations
GBV	Gender-based violence
HIV/AIDS	Human immuno-deficiency virus/acquired immune deficiency syndrome
IDO	International development organisations
ILO	International Labour Organisation
IOM	International Organisation for Migration
KZN	KwaZulu-Natal province
NPO	Non-profit organisations
OHCHR	Office of the High Commissioner for Human Rights
PPE	Personal Protective Equipment
SADC	Southern AfricanAfrican Development Community
SDG	Sustainable Development Goals
SME	Small to Medium Scale Enterprises
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children’s Fund
UNU-EHS	United Nations University-Institute of Environmental and Human Security
WHO	World Health Organisation
WRI	World Risk Index

Executive Summary

The impact of COVID-19 in South Africa, by existing data, has been the most severe on the African continent. South Africa, which accounted for 38.1% of total COVID-19 infections in Africa as of March 2022, is home to approximately 2.9 to 4.2 million migrants, the highest in intra-Africa migration. However, most of the interventions instituted by government to mitigate the socio-economic impact of the COVID-19 pandemic excluded or were not accessible to non-nationals. This defeats the Sustainable Development Goal (SDG) mantra of “leaving no one behind” and the fact that “nobody is safe until everyone is safe”, as emphasised by the World Health Organisation (WHO). Besides the exclusion of non-nationals in pandemic related interventions, the socio-economic impact of the pandemic and difficulties in building back better has led to increasing social tensions over scarce resources, depleting opportunities and deteriorating living standards for many.

South Africa’s economy was already in a technical recession before the pandemic and experiencing record-high unemployment levels amid poor growth forecasts. In addition, a slow pace of accountability in gross misconduct and corruption cases has painted a picture of inefficient state institutions giving rise to the vigilante-style active citizenry. In the process, society’s frustrations are deflected from the actual causes of their plight towards non-nationals, who are now being blamed for the high levels of unemployment, inequality, poverty and crime in South Africa.

In this context, the Brenthurst Foundation research team looked into how non-nationals have survived under such challenging circumstances. The study focussed on how migrant communities, asylum seekers and refugees in South Africa, specifically in Gauteng, KwaZulu-Natal and Western Cape, built resilience, or lack thereof, during the pandemic and the measures taken to curb its spread, such as the lockdown. These three provinces were chosen for this study because they constitute South Africa’s growth hubs, are hosts to the highest proportions of migrants in South Africa and were among the provinces with the highest number of COVID-19 infections. Utilising the structure of the World Risk Index, constructed by the United Nations University’s Institute of Environmental and Human Security as a conceptual framework and a mixed-method approach, the findings reveal the levels, and kinds, of risk and susceptibility non-national communities in South Africa experienced, and the subsequent coping and adaptation strategies they embraced to develop and maintain resilience in the “new normal”.

Although the experiences of non-nationals in South Africa pre- and post-COVID-19 are not mutually exclusive, the onset of the pandemic has highlighted the severity of these experiences. Approximately 200 non-nationals of diverse categories were engaged in this study, namely asylum seekers, refugees, documented migrants with diverse types of permits and undocumented migrants. Different types of international and local institutions that deal with non-national communities were also consulted, including state departments. Ethical clearance for this study was obtained from the South African Medical Association Research Ethics Committee (SAMAREC). In addition to international best

practices, the findings of this study have significant implications for migration management in South Africa in light of subsequent pandemics.

Key findings

- **Documentation:** Refugees and asylum seekers have been rendered irregular due to the Department of Home Affairs' decision to close various branches across the country. This has increased their vulnerability to rising vigilantism and harassment from law enforcement.
- **Discrimination:** Government interventions, narratives and systems that were used to mitigate the harsh socio-economic impact were quite exclusionary.
- **Access to healthcare:** A major challenge for non-nationals in South Africa, contrary to international law and human rights.
- **Statelessness at birth:** Children born to undocumented non-nationals in South Africa are at high risk of being rendered stateless as they have no identity. This needs to be addressed as it increases the stock of undocumented -non-nationals across generations and over time, compounding and sustaining the challenges South Africa faces regarding this demographic.
- **Data:** There seems to be a challenge of inaccurate data on *who is where* in South Africa for moving populations. This makes it difficult for government to know where to find non-nationals for policy intervention purposes.
- **Future-proofing protocols:** The EVDS system will need to be updated for future pandemics as foreign ID numbers were experiencing challenges in trying to register on the system.
- **Policy Review:** There didn't seem to be any specific policies tailored to the needs of the vulnerable, e.g. persons with disabilities, women and children.

What other countries did for non-nationals during the pandemic

Documentation

- Extension of visas, residence and work permits, either automatically or by application, to prevent holders from becoming irregular.
- Facilitation of access to the labour market in essential sectors.
- Regularisation of undocumented migrants to enable access to healthcare.
- Release of migrants and asylum seekers from detention centres, or the implementation of UN conditions for immigration detention.
- Suspension of, or reduction in, deportations

Access to Healthcare

- Universal access to healthcare irrespective of immigration status as a control measure against the pandemic.
- COVID-19 related health expenditure was waived for all, including migrants, refugees and asylum seekers, irrespective of their immigration status.

Statelessness

- On 4 November 2014, UNHCR launched the #IBelong Campaign to end statelessness by 2024.
- Several international frameworks speak to the need to end statelessness, including SDG 16.9, Objective 4 of the Global Compact for Migration, African Charter on the Rights and Welfare of the Child and SADC Resolution on the Prevention of Statelessness and the Protection of Stateless Persons in the SADC Region.
- Several UN agencies are collaborating to address the problem. These include the UN Children’s Fund (UNICEF), which is working on improving birth registration and civil registries, the UN Population Fund (UNFPA), which is helping governments design and implement national censuses and the Office of the High Commissioner for Human Rights (OHCHR), which is supporting the monitoring of the human rights of stateless people.

Recommendations for South Africa

Documentation

- DHA in South Africa should consider extending its recent technological innovations across a wider range of services for South African citizens as well as asylum seekers and refugees who can regularise their documentation. It further affects their children’s schooling and reports of gender-based violence.

Access to healthcare

- The difficulties met by non-nationals in accessing healthcare need to be addressed comprehensively in line with international law and human rights. This scenario of poor access to healthcare and becoming irregular poses a severe threat to societal safety in controlling the spread of the pandemic. Due to challenges with accessing healthcare, a sizeable cohort has never known their status, nor have they ever tested for COVID-19.

Statelessness

- Statelessness needs to be addressed in line with the UNHCR “end statelessness” initiative deadline by 2024. Policy differentiation is required in order to avoid systemic

abuse. Several international frameworks to which South Africa is a signatory speak to the need to end statelessness, and organisations are working on this, which could assist South Africa in this regard, e.g. UNICEF, UNHCR, UNFPA and OHCHR.

Collaboration with private sector and other relevant organisations

- Collaborating with the private sector and relevant local and international development organisations can help to reach everyone and lead to better outcomes. The private sector could have been brought on board to reach all nationalities, e.g., MTN, Vodacom, and Cell C.

The EVDS

- The EVDS system will need to be redesigned for future pandemics as foreign ID numbers experienced challenges. For example, the date of birth could have been used for registration purposes to ensure that a diverse range of communities and demographics are captured.

Communication and awareness creation about the pandemic

- South Africa should follow international best practices and translate communication about the pandemic first into local South African languages and secondly French, Portuguese and Swahili to accommodate the international community in South Africa

Attending to the vulnerable in pandemic situations

- In pandemic situations, there has to be a way of attending to the vulnerable, e.g., persons with disability, women and children. Policies and interventions should be specifically tailored towards the vulnerable in society anytime there is a pandemic.

Policy Action steps

Short-term – 3 months

- Reopen processing centres for asylum seekers and refugees to renew their expired documentation, while observing COVID-19 protocols.
- Amend the design of EVDS to permit the use of date of birth to register for vaccination to avoid the challenges with foreign ID numbers.
- Coordinate the provision of COVID-19 related information in local South African languages and in French, Portuguese and Swahili to accommodate the international community in South Africa. DoH messaging should be in multiple languages, not only in English.
- Bring the private sector on board to broaden reach, e.g. Cell phone companies.

Medium-term – 6 months

- Establish online mechanisms through which asylum seekers and refugees could renew their expired documentation
- Formulate policies and initiatives to target the vulnerable, disabled, women and children in COVID related interventions
- Establish partnerships with faith-based, community-based, non-profit and international development organisations to reach non-nationals with initiatives aimed at addressing COVID and other related challenges.
- Outline a plan to resource health facilities in South Africa to be able to handle additional pressure from non-nationals for healthcare.

Long term – 12 months

- Establish a roadmap towards ending statelessness
- Improve access to healthcare for non-nationals in South Africa irrespective of immigration status to ensure universal access to healthcare, in line with international development frameworks and best practices to which South Africa is a signatory.
- Due to resource constraints, non-nationals could be asked to pay for the services required at a reasonable price point. Still, access should be universal in the interest of societal safety.

1. Introduction

The first official COVID-19 case in South Africa was recorded in March 2020. As a result, several initiatives were implemented to curb the number of infections, fatalities and its broader socio-economic impact. The initiatives used included wearing masks in public places, social distancing, washing of hands frequently and, more generally, maintaining good hygiene. In addition, lockdown measures and numerical restrictions on socio-cultural gatherings were used to control the movement of people and events that were likely to be super-spreaders of the virus.

There was a need to maintain a delicate balance between protecting lives and preserving livelihoods, which was difficult for any country to achieve. South Africa, which is currently experiencing a fifth wave of the pandemic, has already seen over 7,000 new deaths from this new wave.¹

The socio-economic devastation caused by the pandemic has been very severe. With the hard lockdown adopted by South Africa to control the spread of the pandemic, unemployment hit an all-time high of 35.5%, and 65.5% for the youth, as of Q4 2021.²

Approximately 2.3 million households reported child hunger as of April/May 2021, with 20 million South Africans going to bed without food.³ With billions of money lost through corruption over the past decade, including funding for COVID-19 initiatives, the slow pace of accountability has created the impression that state institutions are failing, giving rise to an active vigilante-style citizenry. As in previous instances, society's anger is being deflected from the true causes of their predicament, with non-nationals being blamed for South Africa's high crime levels, unemployment and poverty. This has led to rising social tensions and a surge in xenophobic attacks. As of 12 May 2022, there had been 3 852 1480 infections in South Africa, representing 45.78% of all infections in Africa. South Africa featured a recovery rate of 95.67% and 100,599 fatalities.⁴ However, it is believed that deaths are being underestimated.

Government interventions to quickly address the pandemic and the measures used to curb its spread, such as the hard lockdown, significantly stalled economic activity and income-earning initiatives with the strongest impact on the poor, most of whom work in the informal economy. Moreover, this interruption to the economy worsened multi-dimensional forms of deprivations such as hunger and food insecurity, poverty and inequality.

Despite several social protection schemes that have successfully improved well-being, South Africa is still the most unequal country in the world, as denoted by the Gini index of 0.63 as of June 2019.⁵ The top 20% of the population holds 68% of national income, while the bottom 40% account for a meagre 7% of national income.⁶

Interventions that are easy and quick to implement, far-reaching and accurately focused, were required to avoid further deterioration of such stark inequality under COVID-19 conditions. Time was also of the essence to prevent the onset of any social unrest due to unforeseen hardship. As a result, social grants were increased by R350 per recipient. In

addition, a social relief of distress grant of R650 was introduced to cushion the unemployed through the harsh socio-economic impact of the pandemic. Furthermore, sector-based fiscal stimuli were also introduced to ensure the survival of small to medium scale enterprises (SMEs) and sectors like education and health.

1.1 Why such a study?

Interventions implemented in South Africa to mitigate the socio-economic impact of the pandemic have not improved the country's economic landscape as expected. On the contrary, economic hardships have further worsened since the onset of the pandemic. In addition, these interventions largely applied to South African citizens and not non-nationals. South Africa is home to approximately 2.9 - 4.2 million migrants, most of whom work in the informal sector.⁷ South Africa is the leading destination for intra-African migration, accounting for 16.5% of the total migrant population in Africa.⁸ The study focuses on how migrant communities, asylum seekers and refugees in South Africa, specifically in Gauteng, KwaZulu-Natal and the Western Cape, built resilience, or lack thereof, since the onset of the pandemic. These three provinces were chosen for this study because they constitute South Africa's growth hubs, are host to the highest proportions of migrants in South Africa and were among the provinces with the highest number of COVID-19 infections.

Migrants, asylum seekers and refugees have experienced, globally, gruesome challenges since the onset of the COVID-19 pandemic.⁹ Addressing these challenges has strong implications for migration policy management worldwide. Therefore, the Brenthurst Foundation's Research team set out to understand the challenges that non-nationals in South Africa experience and how they managed to build resilience against infection, fatalities and the socio-economic impact of the pandemic.

1.2 What issues were addressed?

Several research questions emerged:

- To what extent were non-national communities vulnerable to the health and socio-economic impact of the pandemic, i.e. what was their level of exposure to risk?
- How susceptible were non-national communities to the pandemic itself and the adverse socio-economic trends triggered by the impact of the pandemic on economic livelihoods?
- How have non-national communities in these provinces coped with the hardships, and what has been their coping strategy?
- How have they adapted to the new realities, and what have been their adaptation strategies?
- What did other countries do to address the needs of non-nationals, and what lessons can South Africa learn from these examples and the findings of this study to help improve its immigration policy management?

1.3 What did the study seek to achieve?

- To ascertain the level of risk exposure of non-nationals to the health and socio-economic impact of the pandemic,
- Establish the extent to which non-nationals in these three provinces were affected by the pandemic and the adverse socio-economic trends triggered by the pandemic,
- To explore what mechanisms they employed to cope with the health and economic hardships triggered by the pandemic,
- Identify adaptation strategies used by non-nationals to survive the new “realities” created by the pandemic,
- To draw from international best practices and extract lessons that can be learned to improve immigration policy management in South Africa and where the policy pen needs to shift.

2. South Africa has the highest recorded cases of COVID-19 in Africa

Since announcing its first official case on March 5 2020, South Africa has emerged to be the country with the most recorded cases of COVID-19 in Africa. As of 12 May 2022, the number of infections was 3,852,148, representing 45.78% of total infections in Africa. However, even with a recovery rate of 95.67%, fatalities were 100,559 cases, one too many.¹⁰ South Africa is currently experiencing a fifth wave of the pandemic, despite 33.4 million vaccinations having been administered.¹¹ Among measures used to curb the spread of the virus, South Africa opted for the hard lockdown approach, which crippled all economic activity except services deemed essential. Borders were closed, trade between countries was heavily disrupted as well as activities along industry value chains. The movement of people and socio-cultural gatherings was heavily restricted. Social distancing, wearing of masks, and the need to sanitise were required in all entries to buildings.

The impact and implications of COVID-19 on South Africa have been extensive – challenging its social, economic, health, political, environmental and technological infrastructure. As with several other countries, the task of saving lives and safeguarding livelihoods proved challenging. But South Africa’s economic woes did not start with the pandemic.

Before the COVID-19 pandemic struck, South Africa was already dealing with an ongoing economic recession and a sovereign rating downgrade. The economy had already entered a technical recession before the COVID-19 pandemic, recording a growth of -0.5% in the fourth quarter of 2019 and -0.1% in the first quarter of 2020.¹² Furthermore, the unemployment rate breached the 30% mark in the first quarter of 2020 before the effects of COVID-19 were registered. According to a study by the Coronavirus Rapid Mobile Survey, some three million people lost their jobs between February and April 2020 as a

result of the pandemic. By Q4 of 2021, unemployment in South Africa stood at 35.5% overall and 65.5% for the youth, the highest ever recorded in the country.¹³

The COVID-19 pandemic has significantly impacted the local economy and the world of work. According to the ILO,¹⁴ it has transformed into an economic and labour market shock, impacting not just the supply but also the demand side. And the country's migrant community has not been spared. In addition to worsening economic livelihoods, there has been an increase in social tensions and xenophobic attacks as society's anger is deflected from the real causes of their predicament towards non-nationals who are being blamed for South Africa's high levels of crime, unemployment and poverty.

Despite South Africa theoretically including asylum seekers and special permit holders as recipients of a COVID-19 social relief package, access has been challenging for non-nationals, leaving more to be done. The factors that need to be understood in the socio-economic impact of the pandemic on migrant communities include the losses to income due to temporary (and permanent) workplace closures and work stoppages, especially in those sectors deemed as non-essential. Examples include hospitality and industry, bans or entry prohibitions resulting from migrant workers overstaying and the inability to repatriate due to loss of income.

Home to the largest stock of migrants in Southern Africa, it is important to understand the impact and effect of the pandemic on South Africa's migrant workers – and how these could be mitigated as the country builds an economic ramp to offset the enormous loss to livelihoods.

Macroeconomic conditions in the country are likely to remain tough for the next few years. It is thus imperative to understand the state of migrants today, how they developed/built resilience towards the socio-economic impact of the COVID-19 pandemic, and how they can be better supported.

3. How was the study done?

3.1 Conceptual framework

The World Risk Index (WRI) was used as the conceptual framework for this study. The WRI, constructed by the United Nations University-Institute of Environmental and Human Security (UNU-EHS), consists of four components: exposure to the risk of disaster, susceptibility, coping capacity and adaptive capacity.¹⁵ Exposure to risk refers to the level of vulnerability of a person to the pandemic. We assess this using the quality of the living conditions of the respondent, i.e. shelter and household size, access to water and the reliability of supply, sanitation and waste management, the quality of health care available to an individual and whether they have medical insurance or not, their most frequently used mode of transport and time spent commuting. Susceptibility refers to the experience of the respondent with the pandemic itself, i.e. whether they or someone in their household ever got infected, if they have any co-morbidities and how that influenced their experience with the pandemic, their source of information about the pandemic, the

impact on their livelihoods and the psychological effect of the pandemic on their well-being. Coping capacity explored strategies non-nationals used to survive their experience with the pandemic and its attendant socio-economic effects.

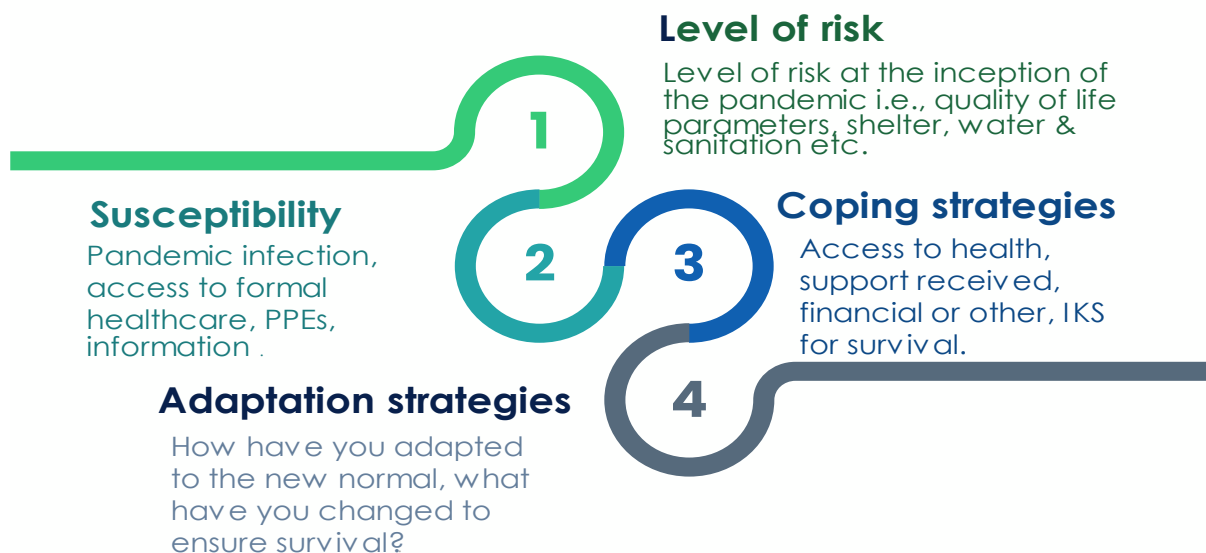


Figure 1: World Risk Index Framework

Source: United Nations University-Institute of Environmental and Human Security (UNU-EHS)

Here we explored how they maintained income and job security, built resilience or the lack thereof in terms of health remedies, whether they got vaccinated or not and whether they received any support from government or social networks. Adaptive capacity relates to what changes non-nationals have made in their daily lives, careers, health and families to survive the “new normal”, subsequent pandemics and life in general.

3.2 Data Collection and Analysis

A mixed-method approach that encapsulates quantitative and qualitative analysis was adopted for this study. Technically it includes a review of relevant documents and literature, analysis of secondary data, sampling, design and piloting of draft data collection tools, finalisation of data collection tools, data collection, data capture, cleaning and analysis, study report writing, validation workshop of a draft report, and the finalisation of the report. Due to COVID-19 restrictions, COVID protocols had to be observed in collecting the data in the three provinces used in this study. Key informant interviews (KIIs) and focus group discussions (FGDs) were held in person and online.

3.3 Sampling: Theoretical underpinnings of the sampling framework

A non-probability sampling approach was used in this study due to the exploratory nature of the qualitative aspect of the study, specifically purposive sampling. The sample was elusive in nature, respondent-driven and involved some snowballing techniques.¹⁶ Consequently, the respondent selection criteria were pre-determined. Purposive sampling is informed by strategic choices and is synonymous with qualitative research. Some of the principles of purposive sampling that was particularly relevant for this study include:

- it should be based on the population of Gauteng, KZN and Western Cape non-nationals.
- they should fall within the working age, live and work in these three provinces
- their immigration status during data collection should not disqualify them from participating in this study

In the process, the sample engaged different categories of actors in the migrant community, detailed below as follows:

Institutions:

International development organisations – 4

State departments – 5

Domestic institutions (CBOs, advocacy & NPOs, faith-based organisations, research, academia)- 8

Individual non-nationals

Circa 200, 18+ years, (UNHCR definitions)

Refugees: People who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country.

Asylum seekers: Fled their country of origin and are seeking permanent sanctuary in another country; however, decisions on their applications have not yet been finalised.

Documented: Permanent residents, temporary permit holders, spousal visas, critical skills and others.

Undocumented: Do not fall into any of the categories above and are in South Africa illegally

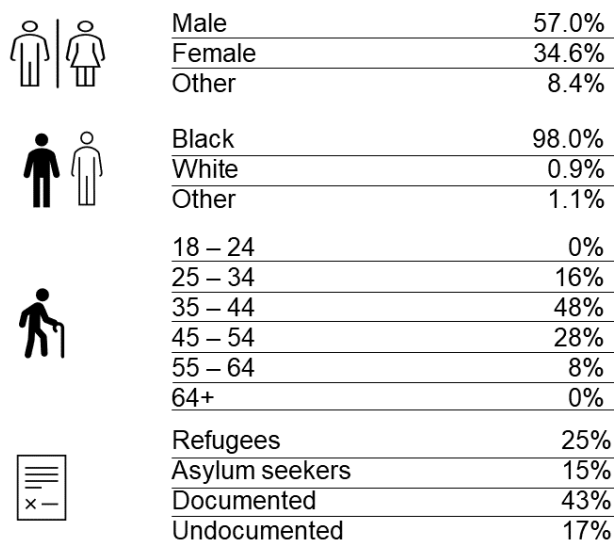


Figure 2: Respondent Profile

Source: The Brenthurst Foundation Research Team

Figure 2 details the profile of the respondents engaged in this study. Respondents were majority black African and working age, 57% male, 35% female and 8% other, with diverse immigration statuses.

4. Key findings

4.1 Qualitative insights

- The narrative and policy discourse on migration is changing to reflect a much broader concept of human mobility, of which migration is a subset. This distinction recognises the heterogeneity among moving populations required to enable the differentiation of policy that addresses the needs of different categories of people on the move.
- In the South African context, the labels “migrant”, “foreign nationals”, and “foreigner” attract negative connotations as they are stereotypically associated with crime and other negative social tendencies. This stereotyping fuels anti-foreigner sentiments that sometimes endanger lives and livelihoods in South Africa.
- Most migrant and non-national related interventions are from faith-based organisations, advocacy & non-profit organisations, law firms and community-based organisations, as opposed to the government. However, the Department of Social Development is engaged in work on missing and unaccompanied children with a number of international organisations.

- Programs that integrate migrants into society are non-existent in South Africa. This is because migration management policy in South Africa is reactive and troubleshooting in outlook. Hence, migrants “self-select” into available social networks and communities where they think they are welcome and can easily integrate and stay below the radar, especially if undocumented. However, they are sometimes wrong and not always welcome, which fuels social tensions.
- The total number of undocumented migrants in South Africa is not known.
- Children born in South Africa to undocumented non-nationals are stateless.
- Home Affairs processing centres for asylum seekers and refugees have been closed since 2012 in Western Cape. As a result, and in addition to the COVID lockdown measures across other provinces, many refugees and asylum seekers have been rendered “undocumented”.

4.2 Level of risk faced by non-nationals

The level of risk faced by non-nationals was assessed based on their demographics and the quality of their living standards in South Africa. Exposure to the pandemic among non-nationals varied with their documentation status and skill level, which together determine employability and ultimately the quality of one’s living standards in relation to shelter, access to essential services, quality of health service delivery, type of transportation used and time spent commuting.

The study divided the level of risk into four main categories:: low, moderate, high and very high. Undocumented migrants, mostly unskilled, unemployed, living in informal dwellings, using public transport with poor access to services and healthcare, faced the highest level of risk to the pandemic. Their level of risk was driven by the poor quality of shelter, low access to water and unreliable water supply, poor sanitation and waste management in the areas they live in, poor access to healthcare, and public transport use. This is because the lack of documentation and skills constrain their access to work, income and access to quality healthcare services.

As a result, they self-select to stay in very deprived communities in informal areas where they believe they can easily stay below the radar without being detected or where they could easily integrate into society. This is one of the drivers of social tension since these communities are not prepared to host migrant inflows whose presence makes already scarce resources further constrained. This also reflects the national scenario of poor service delivery in informal settlements and challenges to quality health service delivery for the poor in South Africa, irrespective of nationality.

The category of non-nationals that faced a high level of risk to the pandemic was not significantly different from those facing very high levels of risk. The differentiating factor for the former category is that some respondents were low skilled, which afforded them

some income-earning opportunities unavailable to the unskilled. However, the factors driving their level of risk were similar.

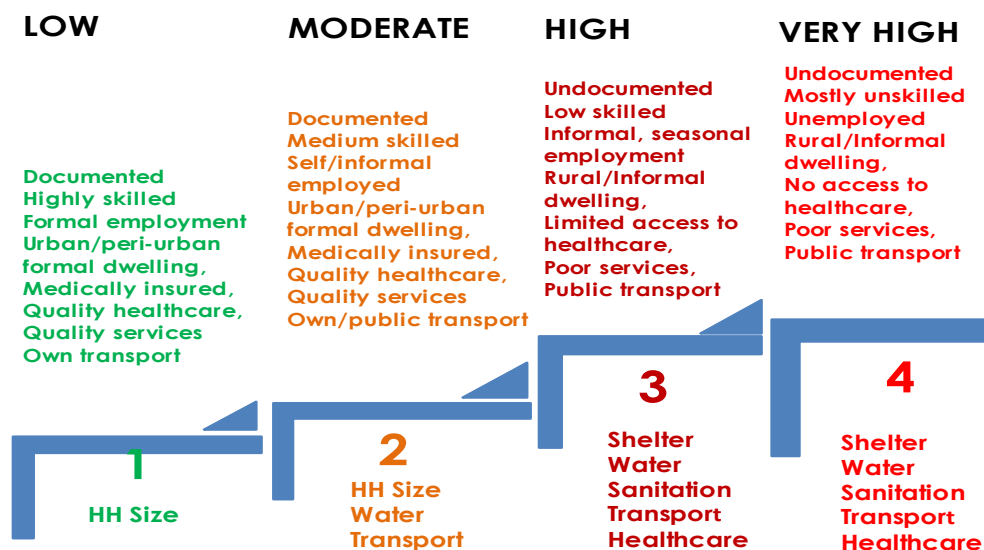


Figure 3: Level of risk to COVID-19 for non-nationals in South Africa

Source: Brenthurst Foundation

The level of risk declines along the spectrum of changes in these parameters to moderate and low-risk levels. Non-nationals facing the lowest level of risk were those with proper documentation, highly skilled and working in formal jobs with stable incomes. They afford and live in formal dwellings, mostly urban areas with improved levels of service delivery. They are medically insured, and either drive their own cars or use e-hailing services. This enables them to avoid crowded spaces and observe COVID-19 protocols such as social distancing and sanitising. The main driver of risk for this category was household size, as migrants are known to have or live within large families. Approximately 39% of this cohort have a household size of 4-6 people, which can be a crowd depending on the space in which they live.

4.3 Susceptibility to the pandemic

This aspect of the study related to what the experiences of non-nationals have been vis-à-vis the COVID-19 pandemic itself. The focus of the enquiry was about whether respondents were infected with the virus or not, do they have any comorbidities, did someone in their household get infected, were they able to test for COVID-19, if someone got infected, was there any contact tracing, were they able to access health services, if not, which types of remedies did they use to survive.

The study also enquired about respondents' source of information about the pandemic, the psychological impact of the pandemic and its socio-economic effects on their well-being and how it affected their work and income flow.

Infection and co-morbidities

Responses to the above again varied with immigration status. Approximately 60% of the documented cohort admitted to experiencing COVID-19 symptoms, 75% of them got tested for COVID, some through PCR tests since they had to travel, with 30% admitted to testing positive for COVID. A further 54% of them admitted that someone in their households experienced COVID symptoms, with 40% admitting that a household member tested positive for COVID.

The refugees, asylum seekers, and undocumented migrants engaged in this study reported not knowing whether they had COVID or not because they never tested for COVID. However, they admitted to falling sick, with one respondent admitting, "*It must have been COVID*".

Expired documentation and vulnerability to law enforcement made most of them avoid public places of service delivery, with vigilante groups posing a more recent risk. However, a slight disparity was observed among the asylum seekers and refugees who were married, had families and lived in peri-urban settings. This group had access to public hospitals, which they had been utilising prior to the pandemic and probably already had a profile as families. Consequently, they got tested when they visited public hospitals and clinics. However, this constituted only about 10% of the sample.

The documented cohort was also more aware of their comorbidities than the other categories of non-nationals surveyed. Since they have valid documentation, and most of them were medically insured, access to quality health service delivery was not a problem. Hypertension featured as the most mentioned co-morbidity among the documented cohort (10%), with 77% claiming they had no co-morbidities and 7.5% preferring not to say their co-morbidities. Asthma and cancer were the other co-morbidities mentioned by the documented cohort (2.5% of the cohort in each case). There was less awareness of co-morbidities among asylum seekers, refugees, and undocumented cohorts. Most of them reported no co-morbidities whatsoever or avoided answering that question.

Source of information

Differences emerged among the non-nationals engaged in this study concerning their sources of information on the pandemic. Besides the formally televised addresses made by the President of the Republic, information was obtained daily from different sources. For the documented cohort, television and radio were their most prominent sources of information on COVID-19, followed by social media, family and friends and the Department of Health (DoH) messaging, in that order. Thus, the documented cohort

received accurate and balanced information about COVID-19 and changes in the rules and regulations. In the case of asylum seekers, refugees and undocumented cohorts, social media and family and friends were the most prominent sources of information on COVID. This created differences in the quality of the information received by the different cohorts. Reported speech among family and friends tends to change as communication evolves, while social media was a source of massive misinformation regarding the pandemic. Television and radio also featured as a prominent source of information on the pandemic for the married families living in peri-urban dwellings.

Work and income flows

Asylum seekers and refugees who work as car guards, waiters, waitresses or security were able to work for a few hours as the lockdown restrictions started to ease. There was, however, a total collapse of livelihoods for many others, especially those who worked in the informal sector, self-employed, or tourism sector. The documented cohort, most of whom work in the formal sector, were able to work from home and sustain income flows. However, there were massive firm closures among SMEs, travel and tourism, agriculture, industry and services, especially where they were not considered essential. As a result, the undocumented cohort had to rely on limited opportunities that emerged very inconsistently.

Psychological impact

Respondents were asked to indicate in order of prominence what the psychological impact of the pandemic was on their well-being. They were asked to indicate how they felt during the pandemic and whether they felt relaxed, comfortable, motivated, hopeful, worried, anxious, stressed, frustrated, unmotivated or other.

Among the documented cohort, respondents were mainly anxious and stressed, while among the asylum seekers, refugees and undocumented migrants, frustration and worry were prominent descriptions of the psychological impact of the pandemic. This indicates that the feeling of hopelessness was stronger among the latter cohorts. Reasons cited for such traumatic experiences included “*deaths of close friends and family*”, “*loss of income-earning opportunities*”, and “*the stress of not knowing where the next meal will come from.*”

4.4 Coping strategies

Strategies adopted by non-nationals to cope with the pandemic’s health and socio-economic impact were also explored. In this category, respondents were asked what they did to protect their health and improve resilience against the pandemic, whether they had been vaccinated, whether they obtained any social support to help them cope, and what they did to sustain their livelihoods and income flows.

Healthcare and vaccination

In terms of health, while a meagre 26% of the documented cohort received treatment from a qualified medical professional, as much as 87% admitted using traditional medicines and methods to sustain their resilience towards the pandemic and strengthen their immune systems. This underlines the predominant role of indigenous knowledge systems in non-national communities even where there is access to formal and quality healthcare. This was captured by respondents as follows: “*We are African, so your ginger, garlic, chillies, cinnamon, pineapple peels and other traditional methods always come in handy*”, “*we share and exchange these traditional medicines among ourselves*”, and “*we have known and used these for centuries, and these are tested over time*”. The experience was no different for asylum seekers, refugees and undocumented migrants due to expired documentation and the lack thereof for the latter cohort.

In addition to the methods above, non-nationals also mentioned “*steaming traditional medicines in hot water*” and “*drying beddings and clothing in the sun*” as some of the additional remedies employed. Besides documentation barriers, there was a high level of fear and mistrust between non-national communities and formal hospitals and clinics during the pandemic. This was fuelled by a social media frenzy about “*putting South Africans first*” in terms of ventilators and oxygen, which were in short supply during the early stages of the pandemic in medical facilities. Furthermore, it was alleged that foreign nationals who lost their lives during the pandemic while hospitalised passed because of deliberate neglect by health officials. The perception was then created that it was not advisable to seek formal medical help during the pandemic regardless of the non-national’s condition or state of health. This created a heavy reliance on indigenous knowledge systems, traditional medicines, and for some, the “*tested truth of the founding fathers*”, a reference to orthodox African spirituality, most of which have been known among non-nationals for centuries and are common practice across the different nationalities.

The same negative sentiments and perceptions drive vaccine hesitancy among non-nationals in South Africa. In addition, the design of the Electronic Vaccination Data System (EVDS), which was used to register for vaccination, was not compatible with the nature of the documentation of non-nationals, which created challenges for the few willing to register for vaccination.

Social support

The usual social networks that migrants depend on were unavailable during the pandemic. These included national, ethnic and tribal associations, stokvels, and industry associations. This is because of the nature of the pandemic and the fact that measures used to control its spread and impact required “*everyone to stay away from everyone.*” This affected social networks and the social capital of non-national communities, as captured by one respondent, saying, “*We cannot gather anymore due to social distancing.*”

However, faith-based organisations, Community-Based Organisations (CBOs) and Non-Profit Organisations (NPOs) managed to get through to non-national families with food packages and some basic first aid and chronic medication. International development organisations also reached some communities with food vouchers, chronic medicines for HIV/AIDS and Tuberculosis, temporary shelter, personal protective equipment and sanitisers, and financial assistance in a few instances. Victims of gender-based violence (GBV) were also supported by some faith-based and legal organisations during the lockdown periods. Such victims could not report their cases to the police because of the lockdown, expired documentation and fear of harassment by law enforcement officials. A few initiatives for community awareness creation were also spearheaded by some domestic CBOs, NPOs and international development organisations. This was done in collaboration with the DoH. In general, families had additional responsibilities for childcare, either for an infected parent on admission or in quarantine.

Work and income flow

The documented cohort largely managed to save their jobs and income flows. As much as 73% of them were able to work, albeit with minor adjustments such as working from home and changes in the number of hours worked. However, 19% lost their jobs, while 8% were unemployed at the time of the study. The 19% who lost their jobs were mostly self-employed operators of SMEs and those working in the hospitality, agriculture and services industries. Of the 73% who worked during the pandemic, 32% earned less than their usual wages, while 41% earned more or less the same wages as before the pandemic.

Documented non-nationals were also able to access some of the relief measures instituted by the government. Although most of them (73%) did not receive financial assistance from anyone, approximately 4% benefited from the Unemployment Insurance Fund-Temporary Employee Relief Scheme (UIF-TERF), and 8% received assistance from a bank or an accredited financial provider. The rest (15%) received financial assistance from family and friends, community formations such as stokvels, loan sharks, faith-based organisations, some donation scheme, or an international development organisation.

The contrary applies to the other cohorts: asylum seekers, refugees and undocumented non-nationals. Most of them lost their jobs during the various stages of lockdown and had no access to government interventions due to expired documentation. The undocumented cohort depended then on friends and family, charity from organisations and irregular income-earning opportunities. Some asylum seekers and refugees disclosed receiving help from former clients, charity from organisations and, in some instances, had to take their services door-to-door to the client through creative, clandestine and innovative mechanisms, especially handypersons and those in the food, beauty and personal grooming industries. This is because of the hard lockdown approach adopted by South Africa, which was further enforced by law enforcement officials, including the army.

4.5 Adaptation strategies

Respondents were asked what changes they have made in their personal lives, career and work, attitudes towards healthcare and in their families, households and living standards to enhance their resilience and survival since the onset of the pandemic

Sentiments across all cohorts included, *“I have learnt to save more”*, and *“live within my means.”* Other responses included, *“the pandemic has made it clear to me that I need to have multiple sources of income”*, and consequently, *“I have learnt to take my hobbies very seriously”*. This is because some hobbies can be developed into income-earning opportunities. Others working in the informal sector, such as the food, beauty and personal grooming industries, have *“learnt to take the service to the customer”*. Finally, the more sophisticated ones have established mobile phone apps for their clientele to make bookings for their services to manage income flows better.

Healthwise, there is a heightened awareness across all cohorts to be more *“health-conscious”*, *“eat more healthy”*, *“exercise”*, *“attend to my co-morbidities more seriously”*, and *“get vaccinated.”*

The devastating impact of the pandemic on livelihoods and the loss of lives of close friends and family have increased sensitivities towards *“making more time for the family”*. *“Life is short”*, one respondent intimated.

4.6 Institutional Respondent feedback

Community-based, non-profit, faith-based and international development organisations were also engaged in this study to assess the type of support, if any, that they have offered to non-national communities before and since the onset of the pandemic.

Services offered to migrants, asylum seekers, refugees and undocumented migrants prior to the pandemic did not differ much from services provided after the onset of the pandemic, just that it probably became more urgent and intense.

Before the pandemic

Table 1 outlines services offered by different organisations to non-national communities before the onset of the pandemic.

Type of Service	Description	Target group	Stakeholder
Sexual reproductive health	HIV/AIDS and STDs medication, counselling and awareness creation.	Sex workers, vulnerable migrants in transport corridors and along borders	IDO

Community health	Needs and rights, training workshops, one-on-one dialogues, advocacy	Community health workers and migrants representatives	IDO, CBO, NPO
Regularising migration	Promoting awareness of human trafficking, training and technical support for legislation	Legislators	IDO, NPO
Movement of people	TB and COVID screening for settling migrants into different communities	Migrants groups	IDO, NPO.
Voluntary return & reintegration back home	Assisting voluntary return for stranded migrants and reintegration into countries of origin	Stranded migrants who want to return home	IDO
Legal assistance	Assistance in seeking legal redress on differences with DHA	Migrants, asylum seekers and refugees	NPO, CBO
Food Security	Providing food and street soup kitchens for migrants groups	Migrants, refugees and asylum seekers,	FBO, IDO, CBO, NPO

Table 1: Services offered to non-nationals prior to the pandemic

Source: Brenthurst Foundation

Note: IDO - International Development Organisation; NPO - Non-profit organisation; CBO — Community-Based Organisation; FBO – Faith-Based organisation

Vulnerable non-nationals along border communities and transport corridors were usually offered sexual reproductive health services and medication by non-profits and international development organisations. This includes medicines for HIV/AIDS and other sexually transmitted diseases. Tuberculosis and COVID-19 screening for migrants settling into new communities are also done in collaboration with the UNHCR.

Legislation around human trafficking, training border communities to identify, report and support trafficked people, legal assistance with challenges on documentation and immigration-related problems with the Department of Home Affairs (DHA), and food packages for poor communities were additional services offered to non-nationals by international, faith-based, non-profit and community-based organisations in South Africa.

After the onset of the pandemic

The onset of the pandemic made it more challenging to offer these services. The lack of documentation made locating and targeting beneficiaries difficult due to the lockdown. One of the key challenges during this pandemic period has been food security. An

international development organisation which works in the migration space provided food vouchers for non-national communities in several provinces, including Western Cape, KZN, Gauteng and Mpumalanga. The value of these vouchers ranged between R600 to R700. In Mpumalanga, actual food parcels were distributed to non-national households. These interventions were done between Q3 of 2020 to Q2 of 2021. For instance, chronic medication for HIV/AIDS and Tuberculosis, usually acquired from public hospitals, became a challenge for non-national beneficiaries who public hospitals typically help in this regard.

Some respondents recounted how they were sent away without any medication whatsoever. The medication had to be provided by other organisations to ensure that non-nationals had access to these vital medications. Expired documentation for asylum seekers and refugees resulted in unpleasant engagements with law enforcement; this was worse for undocumented migrants. Victims of gender-based violence could also not report the abuses they were suffering under lockdown conditions because their documents had expired, making them vulnerable to harassment by law enforcement. Advocacy groups, NPOs and international organisations who work in these spaces on many occasions had to intervene and ensure the safety of the non-national concerned.

COVID RELATED INTERVENTIONS			
Intervention	Stakeholder	Description	Comment
ECHO Project	<p>IDOs,</p> <p>IDOs, FBOs, CBOs</p>	<p>Provided food vouchers R600 – R700 in WC, KZN, GP.</p> <p>Food distribution in several provinces</p>	<p>From Q3 2020 – Q 2 2021.</p> <p>Food security was a major challenge under COVID</p>
Health	IDOs, NPOs	Chronic medication, e.g., HIV/AIDS, TB, etc	Migrants are entitled by law to chronic medication from hospitals, but that is not always the outcome.
Interventions in migrant vulnerability to law enforcement	NPOS, IDO	Vulnerability to law enforcement due to expired documents. GBV trauma	GBV victims could not approach the police due to expired documents. This only made them more vulnerable to harassment from law enforcement
PPEs & community awareness creation	IDO, CBO, FBO	Provided masks and sanitisers to communities & social media awareness creation	DoH collaboration
Temporary shelter	IDO, FBO	Provided temporary shelter for migrants	Some migrants lost their rented units due to a loss of income
Financial assistance	IDO	Stipends for groceries and basic amenities.	The lockdowns had a devastating effect on income flows

Table 2: Services offered to non-nationals after the onset of the pandemic

Source: Brenthurst Foundation

In some cases, temporary shelter had to be provided, and in other instances, financial assistance. The Department of Health (DoH) collaborated with some international development organisations to distribute personal protective equipment (PPE) and enhance community awareness of the pandemic and measures to curb its spread.

What could the government have done better?

Respondents across all cohorts were asked what government could have done better to contain the spread of the pandemic and its devastating socio-economic impact. Several responses emerged.

The first point relates to how the populace was addressed in what came to be known as “family meetings” in which the President directed efforts and announced changes in lockdown levels and measures to contain the pandemic. Some respondents intimated that *“It doesn’t help to say “fellow South Africans’ ... [it is] exclusionary in nature and not Ubuntu”, and “[it] creates tension in society, “us versus them.”* This is because migrants aside, *“South Africa has other nationals of all types and sorts, including a diplomatic corps, foreign businesses, students, expatriates, embassies etc.”*

The next issue was that the Department of Home Affairs (DHA) should have instituted online mechanisms through which asylum seekers and refugees could have renewed their expired documents. The closure of its processing centres has badly affected the livelihoods of many refugees and asylum seekers and their families, especially schooling for their children. Their children are not accepted in some schools without the proper documentation. Lack of documentation has rendered them irregular and vulnerable to harassment from vigilante groups and law enforcement. Victims of GBV cannot report their abuse to the police because of expired documents. Although the DHA now has online platforms to facilitate service delivery, they are reserved for South African citizens only. This means the efficiency gains from technological innovation could not be leveraged across the entire range of services offered by the DHA.

In addition, in pandemic situations, there has to be a way of attending to the vulnerable, e.g., persons with disabilities, women and children. Yet, as intimated by one organisation, *“there didn’t seem to be any differentiated policy initiatives or actions that focussed on children, women and the disabled, let alone migrants.”*

There seems to be a challenge of accurate data on who is where in South Africa for non-nationals. This makes it difficult for government to know where to find non-nationals for policy intervention purposes. Thus, collaborating with international development organisations that engage them often can help to broaden the reach of non-nationals and subsequently lead to better outcomes. In this regard, *“[the] private sector could have been brought on board to reach all nationalities, e.g., MTN, Vodacom, Cell C, etc.”*. This is because most non-nationals have cell phones. *“Partnership engagements are key in future”,* respondents emphasised.

The EVDS system had some challenges with the IDs of non-nationals. This made it difficult for non-nationals to register on the system. As indicated by one respondent, *“the design needs a second look for future pandemics, for instance, date of birth could have been used for registration purposes.”*

4.7 Discussion of findings

Analysis of the data collected reveals some underlying dynamics to the plight of migrants in South Africa and how they were affected by the COVID-19 pandemic. COVID-19 opened a new window to the severity of the experiences of non-nationals in South Africa.

It emerged strongly from the analysis of the data that the state of a non-national’s documentation determines to a very large extent their life outcomes in South Africa and ultimately how they experienced the COVID-19 pandemic. These outcomes improve if a non-national has some employable skills in addition to valid and up-to-date documentation. The higher the level of skill, the more employable the non-national becomes. Non-nationals in this category live in urban or peri-urban formal dwellings that usually have access to better quality service delivery, are medically insured with access to quality healthcare and use their own cars or e-hailing services when commuting to desired destinations. This category of non-nationals has higher quality living standards and thus faced the lowest risk of the pandemic. However, their main source of risk was the size of their households and the use of public places such as grocery shops, although COVID protocols such as social distancing and sanitisation were ensured overall.

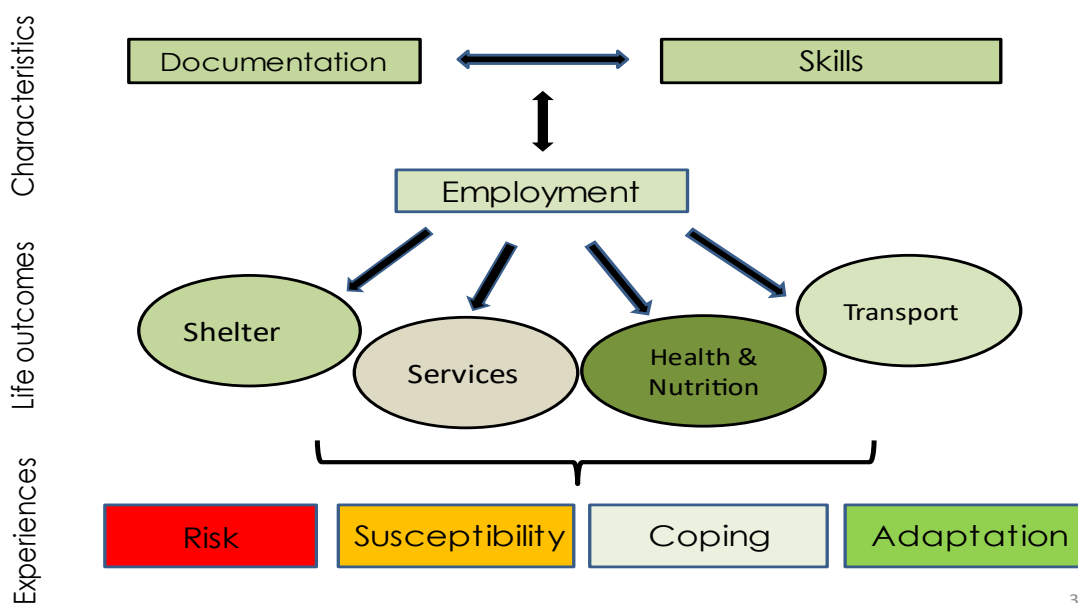


Figure 4: Differentiating factors in the impact of the COVID-19 pandemic

Source: Brenthurst Foundation

Challenges with one's documentation or immigration status, lower levels of skill or the lack thereof, and whether employed or not, translated into an increased risk to the pandemic, driven by factors such as poor quality shelter, crowded informal dwellings and neighbourhoods, poor access to and unreliable supply of water, poor sanitation, poor access to healthcare, the use of public transport and time spent commuting to desired destinations. Although poor service delivery is a general challenge in South Africa, valid documentation, high skill level and a good job enable social mobility for non-nationals into spaces where the quality of their living standards leads to better life outcomes.

Better access to healthcare for the documented and skilled also meant that they could test for COVID-19 and their families and households and were better placed to tell whether they or a family member got infected with COVID -19 or not. They were also more aware of their comorbidities than the asylum seekers, refugees and undocumented cohorts, who had no idea whether they ever contracted COVID or not because they had never been tested. However, they admitted to falling sick at a point in time and had symptoms similar to what was described as COVID. This makes it crucial that measures are put in place to enable easy access to healthcare for asylum seekers, refugees and undocumented migrants, especially if it is COVID-related, to ensure that the accurate level of societal risk is assessed and mitigated with the right type and level of interventions.

As it stands, the level of risk faced by society is not known. However, with the fifth wave gaining momentum each day in South Africa and a worsening winter, there must be efforts to incorporate undocumented migrants into health-related measures as fast as possible.

The documented and skilled migrants received information about the pandemic from more formal sources like TV news, radio and DoH messaging, compared to asylum seekers, refugees and undocumented cohorts, who got their information from social media, family and friends, all of which were traditionally sources of misinformation about the pandemic.

While there is the broader challenge of managing the use of social media in most countries worldwide, it worsens the difficulties of dealing with misinformation in crucial moments, such as during a pandemic. The misinformation on social media about the pandemic created fear among non-national communities. The situation was further worsened by "put South Africans first" campaigns on social media in relation to scarce ventilators and oxygen for hospitalised patients during the height of the pandemic. This depleted the little trust left in non-national communities about the safety of formal health services during the pandemic. Thus many of them resorted to traditional African medicines and natural homemade remedies, even where they had some access to formal healthcare services.

Job losses were minimal among the skilled and documented, except those in the hospitality industry, manufacturing, and related value chain of services, compared to the other cohorts, most of whom lost their jobs mainly in the informal sector and also suffered a more severe psychological impact of the pandemic driven by the deaths of close friends and family, loss of income-earning opportunities and the stress of not knowing where the next meal will come from. They coped through donations of food packages, medication

and PPE from charities, faith-based organisations, legal and advocacy groups, community-based organisations and international development organisations.

There wasn't much evidence of government-driven programmes for non-nationals besides collaboration with DoH and the Department for Social Development (DSD) for community awareness creation and PPE distribution. However, some non-nationals were lucky to receive donations and advance payments from clients, especially those in the beauty and personal grooming industries. There were also opportunities to take the service to clients' doorstep in a few instances.

Traditional social support networks that offered social capital to non-national communities broke down due to the nature of the pandemic and its socio-economic impact. All cohorts heavily depended on traditional African medicines due to the high level of hesitancy towards formal health services and vaccinations. However, traditional medicines were more for reinforcement among the documented and skilled cohort after access to quality formal healthcare. This underlines the strong role indigenous knowledge systems play in African communities, which need to be explored for cross-pollination of knowledge through cultural exchange mechanisms between South Africa and other African countries.

To survive the new normal, the non-nationals we engaged have had to make several changes. Spending and saving behaviours have changed, with most of them alluding to *"saving more"* and *"living within their means"*.

The impact of the pandemic on livelihoods has also made it clear that individuals need to have multiple sources of income to enhance agility and financial resilience. In this regard, some are *"developing their hobbies into income-earning ventures"*, while others have already *"diversified their service offerings"* and, in some cases, *"utilised technological innovation"* such as mobile service apps.

The level of health consciousness has increased, with some people making *"dietary changes towards more healthy eating"*, *"exercising more"*, and *"paying better attention to their comorbidities"*. Vaccine hesitancy has also subsided among non-national communities. Finally, people have become more appreciative of family and admit spending more time with them than before.

Summary of Key findings

Several key issues emerge from this study that warrants policy attention:

- **Documentation:** Refugees and asylum seekers have been rendered irregular due to the DHA closing many of its processing centres across South Africa. This has increased their vulnerability to rising vigilantism and harassment from law enforcement
- **Discrimination:** The narrative, systems and government interventions used to mitigate the pandemic's harsh socio-economic impact were perceived to be exclusionary.
- **Access to healthcare:** A major challenge for non-nationals in South Africa, contrary to international law and human rights.

- **Statelessness at birth:** Children born to undocumented non-nationals in South Africa are stateless. This needs to be addressed as it increases the stock of undocumented non-nationals across generations and over time, compounding and sustaining the challenges South Africa faces regarding this demographic.
- **Data:** There seems to be a challenge of inaccurate data on who is where in South Africa for moving populations. This makes it difficult for government to know where to find non-nationals for policy intervention purposes.
- **Future-proofing protocols:** The EVDS system will need to be updated for future pandemics as foreign ID numbers were experiencing challenges in trying to register on the system.
- **Policy Review:** There didn't seem to be any specific policies tailored to the needs of the vulnerable, e.g. persons with disability, women and children.

5. What are other countries doing – international best practices

5.1 Documentation

Extension of visas, residence and work permits¹⁷

This was done either automatically or by application to prevent holders from becoming irregular. There were three variations to this policy

- Automatic extension¹⁸,
- Extension by application and rapid processing¹⁹,
- Policy differentiation based on the nature of the document held by the applicant.²⁰

Facilitation of access to the labour market in essential sectors²¹

- Migrant workers were allowed to change employers and sectors to strengthen capacity shortfalls in essential sectors during the pandemic.²²
- The recruitment of foreign health workers was expedited into the national health services to mitigate shortfalls in the capacity to handle the pandemic.²³
- The recognition of foreign qualifications of health professionals was accelerated to enable them to start work in the health sector, accelerating the recognition of foreign qualifications of health professionals.²⁴

Regularisation of undocumented migrants to enable access to healthcare²⁵

Several UN organisations recommended the regularisation of undocumented migrants as one of the most efficient ways of ensuring access to health services to effectively mitigate the impact of the pandemic and curb its sporadic spread. However, implementation at the national level took diverse forms.

- Bahrain and Kuwait implemented a limited amnesty for all irregular migrants

- Portugal granted residency status for a limited period for all foreigners with pending applications whose processing could not be completed before the lockdown to enable them to access healthcare, public services and the labour market.
- Peru decreed that all foreigners awaiting regularisation are to be considered regular for the duration of the pandemic.
- Spain temporarily suspended its requirements for employment and minimum income for irregular migrants to make ends meet.
- Greece and Italy also suspended requirements for undocumented migrants, refugees and asylum seekers working in essential sectors.

Release of migrants and asylum seekers from detention centres, or implementation of UN conditions for immigration detention²⁶

There were two main dimensions to this:

- Several countries, including Austria, Belgium, France, Germany, Italy, Spain, Sweden, the Netherlands and the United Kingdom, released migrants and asylum seekers from detention centres to reduce the risk of contagion from the pandemic.
- Other countries kept them in detention, among them Australia, India, the Republic of Korea, South Africa, Thailand and the United States.

Suspension of or reduction in forced return²⁷

This took three different dimensions:

- Suspension of forced returns because of the pandemic. This was implemented by countries like Canada, Chile, Czechia, Finland, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Russian Federation, Slovakia and Spain
- A reduction in forced returns but not a complete suspension. Countries that practised this included Austria, Belgium, Bulgaria, Colombia, Croatia, Estonia, France, Germany, Greece, Israel, Italy, Norway, New Zealand, Portugal, Slovenia, Sweden and Switzerland.
- Continuation of forced returns unabated, e.g. Republic of Korea, USA.

5.2 Access to healthcare²⁸

Many countries have followed the ILO and WHO directives to ensure that migrants have access to healthcare irrespective of their immigration status during this pandemic. Different countries have used several approaches. For instance, those in Argentina, Korea, Thailand, and some 20 EU countries used some variation of the following:

- Offered universal access to healthcare as a control measure against the pandemic, including for migrants, refugees and asylum seekers irrespective of their immigration status,

- Waived COVID-19 related health expenditure for all, including migrants, refugees and asylum seekers, once a person tests positive.
- In Korea, the requirement for hospitals to report illegal or undocumented migrants to authorities was waived during the pandemic, but testing and treatment had to be paid for.
- In Peru, non-nationals were automatically temporarily affiliated with the national health insurance system once they tested positive for COVID-19.

These initiatives in the health sector also made it easy to access vaccines and PPEs for non-national communities, including migrants, refugees and asylum seekers, irrespective of immigration status.

Communication on COVID-19²⁹

Non-national communities have been difficult to reach due to language barriers. However, countries like Turkey led the way by providing relevant information in Arabic, French, Urdu and Farsi. Denmark followed this exemplary innovation and translated COVID-19 related information into 25 languages for migrants and refugees. These examples are now being followed by many other countries, especially in the EU region.

5.3 Statelessness

Statelessness, a major global challenge, refers to the condition of a person who is not considered a national by any State under the operation of its law, including persons whose nationality is not established.³⁰ Being stateless has severe implications, including the lack of identity, access to education, healthcare and basic human rights. A number of global and regional frameworks address the issue of statelessness and require countries to implement measures to eradicate it.

#	Framework	Description	Organisation
1.	#IBelong campaign.	End statelessness by 2024	UNHCR in 2014
2.	SDG 16.9	Provide legal identity for all, including birth registration, by 2030.	UN Sustainable Development Goals, Agenda 2030
3.	Global Compact for Migration Objective 4	Ensure that all migrants have proof of legal identity and	The first Intergovernmental agreement on migration brokered by the UN.

		adequate documentation	
4.	African Charter on the Rights and Welfare of the Child	Every child has the right to acquire a nationality,	
5.	Draft Protocol to the African Charter	Specific Aspects on the Right to a Nationality and the Eradication of Statelessness in Africa	AU's Specialised Technical Committee on Migration, Refugees and Displaced Persons
6.	SADC Member States to develop and adopt a SADC Ministerial Declaration and Action Plan on Statelessness	Resolution on the Prevention of Statelessness and the Protection of Stateless Persons in the SADC Region	SADC Parliamentary Forum in 2016

Table 3: Frameworks that address statelessness

In spite of numerous international frameworks that speak to the need to end statelessness, it remains a global challenge in migration policy management. Several UN agencies are collaborating to address the problem, including the UN Children's Fund (UNICEF), which is working on improving birth registration and civil registries, and the UN Population Fund (UNFPA), which is helping governments design and implement national censuses. The Office of the High Commissioner for Human Rights (OHCHR) also supports monitoring the human rights of stateless people.

6. Conclusion

This study set out to explore how non-national communities in South Africa, specifically Gauteng, KZN and the Western Cape, have survived the health and socio-economic impact of COVID-19. These three provinces were chosen for this study because they are the growth hubs of South Africa, are hosts to the largest non-national populations and were among the provinces with the highest levels of COVID-19 infections in South Africa. Using the structure of the World Risk Index as a conceptual framework and a mixed-method approach, the study engaged migrants, refugees, asylum seekers, and documented and undocumented non-nationals to explore how exposed they were to the risk posed by the pandemic, what their experiences were with the pandemic, how they have coped through

from the onset of the pandemic, the measures used to curb its spread, and what they have changed in their personal lives and careers to adapt to the new normal.

The level of risk posed by the pandemic was assessed using the quality of their living standards in terms of shelter and size of their households; access to water and reliability of supply, sanitation and waste management; access to quality healthcare and whether they were medically insured or not and, their most frequently used mode of transport and time spent commuting.

Their susceptibility to the pandemic was assessed based on whether they or someone in their households ever got infected, whether they had any co-morbidities and how that affected their experience with the pandemic, their main sources of information about the pandemic, and the psychological impact of the pandemic and how it affected their income and job security.

The coping capacity of non-nationals engaged in this study was also explored by assessing what they did to preserve their jobs and income flows, whether they received any support from family or any social networks, which health remedies they resorted to using and whether they were able to get vaccinated or not.

Furthermore, the adaptive capacity of the non-national communities was assessed to see what they have changed in their daily lives and careers, what they have done about their health and access to healthcare, and their living standards to sustain resilience against the pandemic's persistently adverse socio-economic impact.

The study's findings showed that the state of a non-national's documentation, irrespective of immigration status, is the key factor that determines his or her life outcomes in South Africa. These outcomes are further enhanced if the non-national is skilled. These two factors together, i.e. valid documentation and skills, enhance the employability of the non-national and the possibility of earning a secured income, which then determines their access to quality shelter, reliable basic service delivery, access to quality healthcare and nutrition, and safer mode of transport in terms of the contagion effects of the pandemic, compared to the use of public transport and time spent commuting. The level of risk faced by non-nationals to the COVID-19 pandemic was driven by these factors, with the documented and skilled facing the lowest level of risk, while the undocumented and unskilled faced the highest level of risk due to differences in these intervening factors and how they influence the quality of living standards in South Africa.

The study further found that the asylum seekers, refugees, and undocumented migrants engaged in this study had never tested for COVID-19 and could not tell whether they ever got infected or if someone from their households ever got infected. This was due to poor access to healthcare and challenges with their documentation which had expired as a result of DHA closing its offices. This scenario of poor access to healthcare and becoming irregular poses a severe threat to societal safety in terms of controlling the spread of the pandemic. This is because a sizeable cohort has never known their status and is being excluded from measures to curb the spread of the pandemic.

Most asylum seekers, refugees and undocumented migrants also lost their jobs entirely with the onset of the pandemic and due to the hard and extensive lockdown measures employed to curb the spread of the virus. However, the documented and skilled migrants largely managed to keep their jobs, worked from home and had secured income flows, except for those who worked in the hospitality industry, manufacturing and services sectors that were not deemed essential. The informal sector and SMEs also suffered severe shutdowns and loss of income. As the lockdown levels eased, opportunities to work fewer hours emerged for asylum seekers and refugees; however, for the undocumented non-nationals, opportunities were few and far between.

The social networks that offered some social capital to non-nationals broke down completely. To survive, they had to depend on charities, faith-based, community-based and non-profit organisations and international development organisations for food parcels, grocery vouchers, and chronic medication.

A high level of fear and mistrust developed between non-national communities and healthcare delivery centres due to trending online campaigns to put “South Africans first” and anti-foreigner sentiments. Such circumstances emerged concerning the availability and use of ventilators and oxygen that were scarce in hospitals in the early stages and at the height of the pandemic. This raised suspicions of deliberate neglect among non-national communities anytime a hospitalised non-national passed during the pandemic. As a result, non-nationals resorted to relying heavily on African traditional medicines and indigenous knowledge systems known to African communities to survive the pandemic.

There still remains a high level of vaccine hesitancy among asylum seekers, refugees, and undocumented non-nationals for the same reasons of mistrust and fear. It was also challenging to register on the EVDS system due to its incompatibility with foreign ID numbers. Some migrants suggested, for instance, that the date of birth of an individual could have been used for the required registration to ensure easy participation by all.

The psychological impact of the pandemic and the harsh economic consequences it created were more severe for asylum seekers, refugees and undocumented non-nationals compared to their documented and skilled counterparts, who were better equipped to survive in many aspects. This is of immense concern as there are currently no interventions to mitigate mental health challenges of non-nationals and nationals in South Africa.

Regarding what they had changed to strengthen resilience in the new normal, responses received were unanimous on spending less and saving more. To secure income flows, they had learnt to diversify their sources of income, with some converting their hobbies into income-earning ventures. There was also a heightened interest in eating more healthy, exercising more and paying more attention to their comorbidities. Overall, people have learnt to value family much more than before and spend more time with their families.

7. Lessons for South Africa

Documentation

- DHA should consider extending technological innovations across a broader range of services it offers, not only for South African citizens, so asylum seekers and refugees can regularise their documentation. It further affects their children's schooling and reports of GBV.

Access to healthcare

- The difficulties met by non-nationals in accessing healthcare need to be addressed comprehensively in line with international law and best practices. This scenario of poor access to healthcare and becoming irregular poses a severe threat to societal safety in terms of controlling the spread of the pandemic.

Statelessness

- Statelessness needs to be addressed in line with the UNHCR "end statelessness" initiative deadline by 2024. Policy differentiation is needed to avoid systemic abuse.
- Several organisations and international frameworks address the topic and can assist South Africa, e.g. UNICEF, UNHCR, UNFPA, OHCHR, etc.

Collaboration with private sector and other relevant organisations

- There seems to be a challenge of (in)accurate data on where non-nationals are in South Africa. This makes it difficult for government to know where to find non-nationals for policy intervention purposes. Thus collaborating with the private sector and relevant local and international development organisations can help to reach everyone and lead to better outcomes. For instance, private sector entities which cover different segments of the populations could have been brought on board to reach all nationalities, e.g., MTN, Vodacom, Cell C, etc

The EVDS

The EVDS system will need to be updated for future pandemics as foreign ID numbers experienced challenges in registering on the system. For example, the date of birth could have been used to ensure that all people were captured.

Communication and awareness creation about the pandemic

- South Africa should follow international best practices and translate communication about the pandemic first into local South African languages and secondly French, Portuguese and Swahili to accommodate the international community in South Africa

Attending to the vulnerable in pandemic situations

- In pandemic situations, there has to be a way of attending to the vulnerable, e.g., persons with disability, women and children. Policies and interventions should be specifically tailored towards the vulnerable in society anytime there is a pandemic.

8. Policy Action steps

Short-term measures – 3 months

- Reopen processing centres for asylum seekers and refugees to renew their expired documentation, while observing COVID-19 protocols.
- Amend the design of EVDS to permit the use of date of birth to register for vaccination to avoid the challenges with foreign ID numbers.
- Coordinate the provision of COVID-19 related information in local South African languages and in French, Portuguese and Swahili to accommodate the international community in South Africa. DoH messaging should be in multiple languages, not only in English.
- Bring the private sector on board to help reach everyone, e.g. Cell phone companies.

Medium-term – 6 months

- Establish online mechanisms through which asylum seekers and refugees could renew their expired documentation.
- Formulate policies and initiatives to target the vulnerable, disabled, women and children in COVID related interventions.
- Establish partnerships with faith-based, community-based, non-profit and international development organisations to reach non-nationals with initiatives aimed at addressing COVID and other related challenges.
- Outline a plan to equip health facilities in South Africa to handle additional pressure from non-nationals for healthcare.

Long-term – 12 months

- Establish a roadmap towards ending statelessness
- Improve access to healthcare for non-nationals in South Africa irrespective of immigration status to ensure universal access to healthcare, in line with international development frameworks to which South Africa is a signatory.
- Due to resource constraints, non-nationals could be asked to pay for the services required, but access should be universal in the interest of societal safety.

9. Appendix

9.1 Key Informant Interview Questions

A STUDY OF MIGRANT EXPERIENCES IN GAUTENG, WESTERN CAPE, AND KWA-ZULU NATAL PROVINCES UNDER THE COVID-19 PANDEMIC



Strengthening Africa's Economic Performance

www.thebrenthurstfoundation.org

KEY INFORMANT INTERVIEWS

Introduction

My name is I am a researcher with the Brenthurst Foundation. We are conducting a study to understand how migrant communities, built resilience towards infection, fatalities, and the socioeconomic impact of the pandemic in South Africa.

The outcomes of this study will be used to improve future interventions for migrants in South Africa to effectively cope with such health and economic crises that have similarly multidimensional impacts on their lives.

This study includes migrants living in South Africa who fall within the working-age, and live and work in Gauteng, Western Cape, and Kwa-Zulu Natal. You have been selected to participate in this study because you are a member of the demographic.

We are interested to hear about your experiences during this period, the support you received, or lack thereof, and including how your experience might be improved in future. Please note there are no correct responses.

The information you give us will remain confidential and all respondents' identities will remain anonymous. [Explain the consent form at this stage and get participant to sign before responding to queries].

Section A: Respondent profile

GENDER			RACE					AGE					
M	F	O	B	C	I	W	Other	15-24	25-34	35-44	45-54	55-64	65+

MIGRANT STATUS		EMPLOYMENT STATUS (DURING LOCKDOWN)			
DOCUMENTED, type? <input type="checkbox"/> Asylum seeker <input type="checkbox"/> Refugee <input type="checkbox"/> Work Permit <input type="checkbox"/> Permanent residence <input type="checkbox"/> Spousal visa	UNDOCUMENTED	UNEMPLOYED	WORKING FULL-TIME	WORKING PART-TIME	SELF-EMPLOYED

MARITAL STATUS			
SINGLE	MARRIED	DIVORCED	COHABITING

General information

Date of interview	
Occupation of interviewee	
Skill level (see legend below)	
Province	
Urban/Rural/Peri-urban area	
Questionnaire No:	
Interviewer initials, e.g. Mohammed Ali (MA)	

Types of skills levels:

1 = Highly skilled (Finance, Business, Management, Engineering, ICT, Research, Educator, Sales, Marketing, Health Worker, Scientist, etc.)

2 = Semi-skilled (Construction, Hairdresser, Electrician, Sales, Security, Taxi driving, Waitering, Carpentry, Tailor, Delivery, Craftsperson, Child Care, etc.)

3 = Low skilled (Domestic Work, Caregiving, Gardening, Vendor, Cleaning, Fast Food Service, etc.)

Section B: Exposure

1. How many people do you live with in your household?
 - 1-3
 - 4-5
 - 5+

2. What type of accommodation do you live in?
 - Standalone house
 - Apartment or flat
 - Complex
 - Semi-detached
 - Backyard room
 - Informal settlement (e.g. shack)

3. Select your access to water
 - Tap(s) on site (yard/house)
 - Borehole on site (yard or house)
 - Shared tap (neighbour or public)
 - Water carrier or tanker (from government)
 - Water vendor (pay per bucket or container)
 - Flowing water (river)

4. If applicable, please describe how reliable your water source is
 - No water cuts (generally)
 - Water cuts once a week
 - Water cuts 2-4 times a week
 - Water cuts more than 4 times a week

5. Describe your waste removal situation
 - Removed at least once per week
 - Removed less than once per week
 - Communal refuse dump
 - Own refuse dump
 - Infrequent refuse removal

6. Describe your most frequent mode of transport
 - Bicycle
 - Walking
 - Taxi or kombi
 - Bus
 - Train
 - Private car
 - Bakkie
 - Carpooling or lift club
 - Not applicable (e.g., work from home)

7. Describe your average time spent commuting daily

- 30 min – 1hr or less
- 1 – 2hrs
- 2 hrs +

8. Describe your access to health facilities

- Public clinic/ hospital
- Private clinic/ hospital
- Private doctor
- Traditional healer
- Pharmacy
- Other _____

9. Do you have medical aid or medical insurance?

- Yes
- No

10. What was the level of exposure to COVID-19 at your job? You may select more than one.

- I was at high risk of exposure because I was in close contact with people daily
- I was at high risk of exposure because I did not have enough protective gear (sanitiser, masks)
- I was at medium risk of exposure because I could social distance from people
- I was at medium risk of exposure because I had **some** protective gear (sanitiser, masks)
- I was at low risk of exposure because I was not in close contact with people daily
- I was at low risk of exposure because I had enough protective gear (sanitiser, masks, gloves)

Section C: Susceptibility

11. Select the main source of your information about COVID-19?

- Dept. of health SMSes
- Television and radio public advertising
- Social media
- Community health worker(s)
- Family and friends

12. Did you receive COVID-related advice from a qualified medical professional?

- Yes
- No

13. Did you receive COVID-related advice from a traditional doctor, family member or friend?

- Yes
- No

14. Indicate which of the following co-morbidities (underlying conditions) you have

- Diabetes
- Hypertension
- Heart disease

- Tuberculosis
- Cancer
- HIV
- Chronic lung disease(s) e.g. asthma
- None of the above
- Other _____

15. Have you experienced any symptoms of COVID-19 so far?

- Yes
- No

16. Did you ever get tested for COVID-19?

- Yes
- No

a. If yes, under what circumstances were you tested (e.g. for travel purposes, community testing, had symptoms)

—

17. Have you tested positive for COVID-19 so far?

- Yes
- No

a. If yes, did you receive a contact-tracing message?

- Yes
- No

b. Did you receive COVID-related treatment from a qualified medical professional about what to do to recover?

- Yes
- No

c. Did you receive COVID-related treatment from a traditional doctor, family member or friend about what to do to recover?

- Yes
- No

18. Did anyone in your household experience COVID-19 symptoms?

- Yes
- No

19. Did anyone in your household test positive for COVID-19?

- Yes
- No

20. Did you use any remedies (e.g., steaming, herbal mixes, traditional medicine) to boost your immune system against the COVID-19? If yes, where did you hear about them?

- Yes
- No

Section C: Coping Strategies

Financial - Vulnerability, opportunities, impacts of COVID-19

21. How did COVID-19 and the lockdown affect your ability to work? Please explain why.

- I could not work /lost my job during the lockdown
- I could work but with some adjustments during the lockdown
- I could work just as before with little or no changes during the lockdown
- Not applicable, e.g. unemployed

22. How did COVID-19 and the lockdown affect your working hours? Please explain why.

- I worked less hours during the lockdown
- I worked more or less the same hours during the lockdown
- I worked longer hours during the lockdown
- Not applicable (e.g., unemployed)

23. How did COVID-19 and the lockdown affect your salary/wages? Please explain how.

- I earned less money during the lockdown
- I earned more or less the same amount during the lockdown
- I earned more money during the lockdown (e.g., from new opportunities/strategies)
- Not applicable, (e.g., unemployed)

24. If your income was affected negatively by COVID-19 and the lockdown, please indicate if you received financial assistance

- I did not receive any financial assistance from anyone
- I received the Unemployment Insurance Fund-Temporary Employee Relief Scheme (UIF-TERF)
- I received financial assistance from the bank or an accredited financial provider
- I received financial assistance from family, friends, or community members
- I received financial assistance from an informal support scheme (e.g., stokvel, loan shark, church, or donation scheme)

25. How did you sustain or supplement your income flow during the lockdown?

26. Please indicate your level of job security during the COVID-19 lockdown. Please explain why.

- My job was very secure (e.g., I was not worried about losing my job)
- My job was somewhat secure (e.g., I was a bit worried about losing my job)
- My job was not secure at all (e.g., I was very worried about losing my job/lost my job)

27. Do you feel that more could have been done by the South African government, businesses or community leaders to include migrants in support and recovery plans during COVID-19 lockdown? Please explain how, include examples.

- Yes
- No

28. Did COVID-19 have any lasting effects (“new realities”) on how you work or other aspects of your daily life? These may be good or bad lasting effects - please describe them.

- Yes
- No

Social - vulnerabilities, opportunities and impacts of COVID-19

Household and Family

29. Did you experience any additional household responsibilities (childcare/home-schooling/housework), or have to care for a family member(s) during the lockdown? Please specify.

- Yes

No

30. How food secure were you and/or your household during the lockdown?

- Food secure (Mostly had access to three meals per day)
- Semi-food secure (Sometimes had access to at least two meals per day)
- Food insecure (Often had access to less than two meals per day)

31. How did you ensure you had sufficient food during the lockdown? (e.g. food donations)

32. Did you receive any social support from family, friends, or your community? E.g., Advice, assistance with household responsibilities and care duties? Please specify.

- Yes
- No

Psychological impact

33. Please select the following mental and emotional state(s) that best describes your experience during lockdown.

- Relaxed
- Comfortable
- Motivated
- Hopeful
- Worried
- Anxious
- Stressed
- Frustrated
- Unmotivated
- Other _____

34. Did you receive any social support from family, friends, or your community in dealing with or managing your mental and emotional wellbeing during the lockdown? If yes, please explain what kind of support it was and from whom.

- Yes
- No

35. Did you encounter any traumatic experience that severely affected your mental/emotional wellbeing during the lockdown? E.g., homelessness, unemployment, gender-based violence, loss of a friend or family, discrimination, or prejudice, etc.? Please specify/describe?

- Yes
- No

36. If yes, did you receive any social support from family, friends, community or a professional after this about this experience during the lockdown? Was it sufficient?

Section E: Adaptation Strategies

37. Have you made any lasting changes in your daily life to adapt to the new reality? Please specify.

- Yes
- No

38. How has the way you do your work and earn a living changed to adapt to life post-COVID?

39. What changes have you made to you family life and household to adapt to the post-COVID reality?

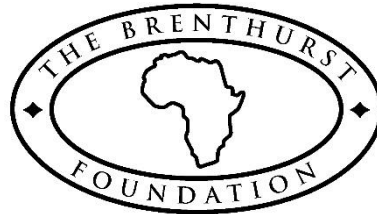
40. How has your attitude and/or access to healthcare (e.g.medicines, insurance) changed to adapt to post-COVID life?

41. Have you made any measures to improve your access to water, sanitation and refuse removal for the long-term? Please describe.

Thank you for your time.

9.2 Institutional Survey

A STUDY OF MIGRANT EXPERIENCES IN GAUTENG, WESTERN CAPE, AND KWA-ZULU NATAL PROVINCES UNDER THE COVID-19 PANDEMIC



Strengthening Africa's Economic Performance

INSTITUTIONAL INTERVIEW

Introduction

My name is..... I am Researcher with the Brenthurst Foundation. We are conducting a study to understand on how migrant communities, built resilience towards infection, fatalities, and the socioeconomic impact of the pandemic in South Africa.

The outcomes of this study will be used to improve future interventions for migrants in South Africa to effectively cope with such health and economic crises that have similarly multidimensional impacts on their lives.

This study includes migrants living in South Africa who fall within the working age and live and work in Gauteng, Western Cape, and Kwa-Zulu Natal. You have been selected to participate in this study because you are an organisation that works closely with members of the demographic.

We are interested to hear about your experiences during this period as an organisation that works with the migrant community, the support you provided and received or lack thereof, and including how your experience might be improved in future. Please note there are no correct responses.

The information you give us will remain confidential and all respondents' identities will remain anonymous. [Explain the consent form at this stage and get participant to sign before responding to queries].

Section A: Organisation Profile

ORGANISATION STAFF/ TEAM SIZE

MEMBERSHIP SIZE

1-10 10-20 20-30 30+ 1-50 50-100 100+

TYPE OF ORGANISATION

COMMUNITY-BASED ORGANISATION (voluntary) GOVERNMENT AGENCY OR ORGANISATION ADVOCACY NON-PROFIT ORGANISATION FAITH-BASED ORGANISATION NATIONAL ASSOCIATION

TYPES OF MIGRANTS SERVED				
<input type="checkbox"/> ASYLUM SEEKERS	<input type="checkbox"/> REFUGEES	<input type="checkbox"/> SPOUSAL VISA HOLDERS	<input type="checkbox"/> WORK PERMIT HOLDERS	<input type="checkbox"/> PERMANENT RESIDENTS (NATURALISED)

Please describe the kind of programmes or services you provided for migrant communities pre-COVID?

Section B: SUPPORT PROVIDED THROUGHOUT LOCKDOWN

1. Has your organisation provided interventions that alleviated the risk level of the migrant community you work with?

- Yes, please explain,
- Somewhat, please explain,
- No

2. How has COVID affected the migrant groupings you deal with in their normal course of work and livelihoods?

3. Did your organisation do anything to intervene or assist these migrant communities in any COVID related way? Please elaborate.

- Donate food and supplies
- Provide financial assistance
- Provide temporary housing or shelter
- Other

4. Which of the following aspects of the pandemic did your organisation provide assistance to mitigate the COVID-related health and socio-economic risks? You may select more than one.

- Exposure to the virus, financial and domestic & psychological challenges
- Susceptibility to the virus, financial and domestic & psychological challenges
- Coping or adapting to the new realities in relation to the virus, financial and domestic & psychological challenges

5. How has your intervention helped migrants to cope with or adapt to the new normal in relation to the disease itself, its socio-economic impact etc.?

6. How was your organisation's work affected by COVID-19 and the lockdown? Please elaborate.

- It was hardly affected (e.g. needed no or few adjustments)
- It was affected negatively (e.g. could not work/constrained)
- It was affected positively (e.g. new opportunities, more work)

7. Are there any interesting experiences you would like to share with us that could add value to our study?

Section C: PERCEPTIONS OF MIGRANT SUPPORT DURING LOCKDOWN

1. What is your view on how SA has handled COVID to date vis a vis *the migrant experience and your organisation* in the following areas?
- a. Lockdown measures implementation

- b. Access to public protective gear (masks, sanitising, social distancing)

- c. Access to healthcare

- d. Socioeconomic interventions

2. Has your organisation been involved with the government in any joint community-based projects? Please describe it.

- Yes
- No

3. How do you think government COVID-19 interventions could have utilised organisations like yours to support the migrant community through the lockdowns?

4. Are there any other interesting insights that you would like to share with us for our study etc.?

Thank you for your participation.

9.3 FOCUS GROUP DISCUSSION GUIDE

A STUDY OF MIGRANT EXPERIENCES IN GAUTENG, WESTERN CAPE, AND KWA-ZULU NATAL PROVINCES UNDER THE COVID-19 PANDEMIC

Introduction

My name is I am a researcher with the Brenthurst Foundation. We are conducting a study to understand how migrant communities built resilience towards infection, fatalities, and the socioeconomic impact of the pandemic in South Africa.

The outcomes of this study will be used to improve future interventions for migrants in South Africa to effectively cope with such health and economic crises that have similarly multidimensional impacts on their lives.

This study includes migrants living in South Africa who fall within the working-age, and live and work in Gauteng, Western Cape, and Kwa-Zulu Natal. You have been selected to participate in this study because you are a member of the demographic.

We are interested to hear about your experiences during this period, the support you received, or lack thereof, and including how your experience might be improved in future. Please note there are no correct responses.

The information you give us will remain confidential, and all respondents’ identities will remain anonymous. [Explain the consent form at this stage and get the participant to sign before responding to queries].

General information

Date of FGD	
Type of Group e.g. Saloon, mechanics etc	
Number of participants	
Province	
Urban/Rural/Peri-urban area	
FGD Guide No:	
Interviewer initials e.g. Mohammed Ali (MA)	

COVID –19 has been with us for a while, it has created a “new normal” for everyone and everything, everywhere.

1. How much risk were you in when the COVID-19 pandemic first hit? As in your (i) living conditions, (ii) housing (i.e. household and neighborhood), (iii) access to water, (iv) sanitation, (v) waste removal etc.

2. Have any of you at any point tested positive? What treatment did you use, and how did you recover? Formal hospitals, traditional medical remedies etc.
3. What are some of the precautions used by migrants to protect themselves from the disease? Any traditional/cultural practices that are famous among the migrant community?
4. The lockdown was quite severe, especially in the early levels, interrupting all income-earning activity. What did you do to survive? I.e. sustain income flow, pay your bills, support your family etc.
5. What were the biggest challenges that you, your family, and other members of the migrant community experienced during the lockdown that has not already been mentioned?
6. What were the main sources of support for you and/or your family during the lockdown? (e.g., individuals, community forums or organisations, government etc.)?
7. What opportunities have arisen during the lockdown that helped you cope that have not already been mentioned?
8. Do you feel that more could have been done by the South African government, businesses or community leaders to include migrants in support and recovery plans during COVID-19 lockdown? Please explain how and include examples.
9. Are there any suggestions you would share with policymakers, businesspeople, and community leaders on how to better include migrants in recovery strategies going forward?

10. References

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- ² Statistics South Africa 2022. Quarterly Labour Force Survey Q4 2021, See <http://www.statssa.gov.za>
- ³ National Income Dynamics Study – Coronavirus Rapid Mobile Survey See <https://www.cramsury.org>
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- ¹¹ Ibid
- ¹² Mills, G and Hartley, R. 2020. Brink of a breakdown: South Africa has reached a critical fork in the road. See <http://www.https://www.dailymaverick.co.za>
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- ¹⁶ Verma (2013) Sampling elusive populations, applications to studies on child labour See <https://www.ilo.org>
- ¹⁷ Scarpetta S, Dumont JC. 2020 Managing international migration under COVID-19. Organisation for Economic Co-operation and Development; See https://read.oecd-ilibrary.org/view/?ref=134_134314-9shbokosu5&title=Managing-international-migration-under-COVID-19,
- ¹⁸ Angola, Argentina, Bahrain, Botswana, Bulgaria, China, Colombia, Croatia, Gabon, Greece, Hong Kong Special Administrative Region (China), Hungary, Ireland, Italy, Japan, Luxembourg, Mauritius, New Zealand, Nigeria, Poland, Portugal, the Republic of Korea, Romania, Saudi Arabia, Slovakia, Spain, Sri Lanka, Thailand, the United Arab Emirates, the United Kingdom, the United Republic of Tanzania and Zimbabwe (28,33–35).
- ¹⁹ Australia, Austria, Azerbaijan, Belgium, Canada, Chile, Finland, Germany, India, Indonesia, Israel, Kenya, Mexico, Mozambique, the Netherlands, the Russian Federation, South Africa, Sweden and Switzerland
- ²⁰ France (automatic extension for 6 months for resident permit holders, short term visas not,) Czech Republic the opposite.
- ²¹ Ibid.
- ²² Czechia, Finland and Saudi Arabia.
- ²³ Argentina, Chile, France, Italy, Peru and Spain
- ²⁴ Belgium, Germany, Ireland, Lithuania, Luxembourg, Spain and Switzerland
- ²⁵ World Bank 2020. Potential responses to the COVID-19 outbreak in support of migrant workers. (<http://documents1.worldbank.org/curated/en/428451587390154689/pdf/PotentialResponses-to-the-COVID-19-Outbreak-in-Support-of-Migrant-WorkersJune-19-2020.pdf>, a
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- ²⁸ UN Network on Migration 2020 Working Group on Access to Services. Enhancing access to services for migrants in the context of COVID-19 preparedness, prevention, and response and beyond. See https://unhabitat.org/sites/default/files/2020/06/final_network_wg_policy_brief_covid-9_and_access_to_services.pdf,
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- ³⁰ UNHCR (1954) Text of the 1954 Convention relating to the Status of Stateless Persons, Geneva. https://www.unhcr.org/ibelong/wp-content/uploads/1954-Convention-relating-to-the-Status-of-Stateless-Persons_ENG.pdf