Research Article

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Authoritarian Violence, Public Health, and the Necropolitical State: Engaging the South African Response to COVID-19

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Abstract: Following COVID-19's arrival in March 2020, the South African government implemented a restrictive state-led response to the pandemic, limiting infections along with the survival strategies of those at greatest risk of illness. While the country's aggressive tactics towards the pandemic have been lauded by some, the public health response has taken a violent turn towards the country's historically marginalized Black urban population. How are we to make sense of the ruling African National Congress' decision to utilize the South African state's capacity for violence towards poor and working-class Black urban communities? How can this disease response be contextualized within the broader dynamics of citizenship across South African history? Building on these questions, I analyze South African efforts to control the COVID-19 pandemic alongside the state response to an outbreak of bubonic plague during the colonial era. I propose that the South African state carries within it divergent historical continuities, some of which carry forward the necropolitical modalities of the colonial and apartheid eras and others that redistribute resources to safeguard life.

Keywords: South Africa, COVID-19, Neoliberalism, Necropolitics, Public Health

1 Introduction

For Arundhati Roy (2020), the COVID-19 pandemic has the potential to serve as a portal, opening a door to a new world where the failures of the present give way to a future based on different social, political, and economic ideals. Building on Roy's invitation to see the current historical moment as contingent and characterized by both crisis and possibility, I focus here on the dynamics of health, inequality, and COVID-19 in post-apartheid South Africa. However, the socio-political dynamics that have unfolded alongside South Africa's response to COVID-19 lead me to revisit Roy's framing of the portal. I propose that the COVID-19 crisis can also serve as a window that allows us to see the past and its lasting impact on the lived realities of the present day. For a post-colonial society such as South Africa, examining these historical continuities alongside a consideration of the modalities of state authority enables one to see how power dynamics informed by history produce constraints on the transformative potential of the present moment.

As part of South Africa's COVID-19 response, there have been significant examples of state violence relative to the country's historically marginalized Black population. Rather than accept afropessimistic perspectives of the continent that portray political violence as an inevitable outcome of ethnic difference and 'tribalism', here I ask why this modality of state power continues to manifest in the post-apartheid context. Why would the ruling African National Congress (ANC), a party that helped to bring South Africa into its democratic age, implement policies that enact lethal violence towards historically marginalized Black South Africans, who also serve as its political base? How are we to situate the violence that has accompanied South Africa's COVID-19 response alongside earlier attempts to control infectious disease outbreaks?

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In order to address these questions, we must contextualize South Africa's response to the COVID-19 pandemic, which has led to mass arrests and more than a dozen deaths at the hands of the country's security forces. The country adopted one of the world's most stringent responses to COVID-19, calling for widespread "lockdown" within weeks of South Africa's first case on March 5, 2020. The broad response from the international community to the ANC's policy was positive, with many seeing this as evidence of strong leadership from South African President Cyril Ramaphosa. The lockdown was to be enforced by both the South African Police Services (SAPS) and the South African National Defense Forces (SANDF), with 70,000 SANDF troops deployed to enforce the public health measures put into place by the ANC. Notably, the directive handed down to soldiers by military commanders called for them to "find, fix and neutralize non-compliers" and to "allow harsh measures to take their course" (York, 2020).

The details leave little question as to whether South African security forces used excess force in implementing the country's COVID-19 lockdown. A notable case involves Collins Khosa, a resident of Alexandra, one of Johannesburg's largest townships, who was assaulted and tortured to death by SANDF members for drinking alcohol in violation of lockdown protocol (York, 2020). Nathan Julius, a 16-year-old child with Down's syndrome, was shot and killed by South African security forces as he walked to a store to buy biscuits (BBC, 2020c). SANDF soldiers have also shot South Africans for simply violating face mask regulations (Shange, 2020). While the number of SANDF troops was later reduced to 20,000 in June 2020, the impact of violent policing took its toll on poor and working-class communities across the country. Clearly, the leadership of the South African state allowed lockdown to "take its course" towards Black urban communities, with lethal violence the predictable effect of these draconian policies.

Amid the pandemic, the South African state has continued forced removals of people from informal settlements across the country. The economic effects of the lockdown hit poor and working class Black urban communities particularly hard, with many unable to continue paying rent without access to wage labor. As a result of increasing deprivation and desperation, people left their homes for informal settlements in peri-urban areas. The South African state responded with violence to these survival strategies, with security forces rendering 1,000 men, women, and children homeless by destroying 575 shacks and homes over a two-day period across southern Johannesburg, for example (Neville, 2020). The post-apartheid South African state's enactment of violence and production of death is a significant tendency that requires further historical and theoretical investigation. While scholars have engaged with the question of violence in various ways, including political violence, anti-terror measures, the Marikana massacre of mineworkers, and the general dynamics of violence in South African society, here I will be focusing on the deployment of violence by the state relative to infectious disease outbreaks (Duncan, 2007; Bruce, 2009; de Haas, 2016).

Anthropological debates on sovereignty have provided significant insight on the exercise of power in ways that negatively affect human life. Giorgio Agamben's (2005) research has underscored how violence associated with sovereign power finds continuity in the expansion of executive power in modern liberal democracies, particularly during times when social conditions are defined as exceptional. For Agamben, the "state of exception" underscores that the exercise of modern power cannot be neatly decoupled from earlier modalities of state power, in contrast to Foucault's (2008) claims regarding a shift towards modern forms of governmentality. Agamben's contribution thus brings to light that modern states act in ways that not only seek to increase productivity, wealth, and human welfare, as Foucault emphasized, but also exercise lethal violence towards particular groups with impunity.

On this point, Achille Mbembe's (2003, 2019) contribution to debates on sovereignty is salient for the case considered here, particularly given that his work focuses on these dynamics from the perspective of the global south. Extending the critique of Foucault's work to the post-colonial context, Mbembe queries the exercise of political authority by post-colonial elites with a focus on the African continent. Drawing parallels from the colonial exercise of political authority via *commandement* to post-colonial authoritarian political tendencies, Mbembe argues that the colonial era set into motion a process whereby the exercise of political power in Africa has become intimately linked with enacting human death, for which he coins the term necropolitics. While investigating the roots of post-colonial political authority in the African context, Mbembe pays careful attention to the dynamics of temporality. In particular, the Cameroonian scholar emphasizes how contemporary academic accounts produce a temporal disjuncture by positing a link between the modality of power associated with European societies during the feudal era and post-colonial African politics. An important example in this regard is the characterization of African societies as neopatrimonial in nature, a concept that invokes Weber's depiction of pre-modern European societies (Pitcher et al., 2009). As Mbembe notes, invoking parallels between these historically particular examples serves to displace African societies into a premodern past and construct them as backwards, deviant, and a continued site of otherness.

Here, I build on Mbembe's critical insights regarding the dynamics of rupture and continuity relative to the modalities of power exercised in the post-colonial context with a focus on the COVID-19 pandemic. For Mbembe, of particular note are moments of political possibility that emerge in unexpected ways, only to be submerged through the re-assertation of necropolitical authority via the post-colonial elite's control of the state and its capacity to produce death. However, the inverse tendency might also be considered: what of societies that have undergone post-colonial transitions and have transformed the state and its capacities to enhance and/or sustain human life? Do necropolitical modalities continue to circulate and re-emerge in these societies, and if so, in what manner?

Alongside the dynamics of state violence, the contours of the COVID-19 pandemic in South Africa underscore the complex ways in which infectious disease epidemics interact with the dynamics of citizenship. Over the past three decades, anthropological accounts have analyzed how local manifestations of the global HIV/AIDS epidemic have transformed citizenship practices. Relative to South Africa, Robins (2006) builds on Petryna's (2002) conceptualization of biological citizenship to analyze how HIV/AIDS activists leveraged biological criteria—their HIV positive status—to make claims on the state to expand HIV/AIDS treatment access. Nguyen (2010) extends this debate by proposing the concept of therapeutic citizenship, which highlights the ways that transnational networks of non-governmental organizations (NGOs) serve as conduits for access to HIV/AIDS treatment. These organizations serve as a non-state means through which citizenship rights are fulfilled for a select few people living with HIV/AIDS in Burkina Faso and Côte d'Ivoire. Whyte et al. (2013) adapt Nguyen's work with the concept of therapeutic clientship. Based on research in Uganda, the authors outline how the relationships between NGOs providing treatment and Ugandans accessing these services operate as a patron-client relationship, with HIV/AIDS treatment provided based on fulfilling particular responsibilities rather than as a human right. Within these accounts, there is a broader focus on how performances of bodily discipline, (HIV) positivity, and claims to citizenship rights enable access to life-sustaining HIV/AIDS treatment. However, relative to the COVID-19 pandemic and the state violence that has accompanied it, a different set of questions arise relative to citizenship: how has the South African state interacted with the country's citizenry within the broader response to the COVID-19 pandemic? What forms of support and discipline has the South African state enacted as part of lockdown, and which populations have these modalities of state power been applied towards?

In order to address these questions and conceptual debates, I will engage with the early phases of the spread and response to COVID-19 in South Africa up through September 2020. As such, subsequent developments relative to both the public health response and the trajectory of the COVID-19 epidemic are beyond the scope of this analysis. Given the limitations on travel and fieldwork associated with the COVID-19 pandemic, the data for this piece is derived from a combination of popular and community-focused media sources rather than first-person observation and participation with communities infected and affected by this newly emergent pathogen. In addition, I review historical literature to draw parallels between the contemporary COVID-19 response and a public health response to a bubonic plague outbreak during the colonial era.

2 Pathogenic Antecedents: Plague and “Public” Health in Colonial South Africa

As the 19th century came to a close, the majority of the world's peoples found themselves under the political, economic, and social control of imperial polities based in Europe. The political and economic integration of the world's societies under the presumption of Anglo-European superiority brought with it social effects that transgressed the boundaries of colonizer and colonized. The industrialization of the global north was accompanied by the development of economies across the global south that specialized in the export of one or two primary commodities based on low-wage labor. While the contours of this “unequal exchange” have been the source of considerable academic debate, it is critical to note that wars of conquest and subsequent colonization increased inequalities and the susceptibility of colonized peoples to infectious disease outbreaks.

As noted by historian Myron Echenberg (2007), the violence and inequality associated with the establishment and maintenance of European empires increased the incidence of infectious disease among colonized peoples. The development of colonial economies, designed in part on the principle of “cost recovery” to recapture resources required to maintain the colonial apparatus, extracted capital and expropriated the means of self-sustenance for colonized

peoples in order to enact export-oriented growth and enhance political and economic conditions for Anglo-European polities and settlers (Rodney, 1972). Outbreaks of infectious disease among the colonized, which included cholera, malaria, yellow fever, and trypanosomiasis, were one effect of increasing precarity. While this era was associated with increasing wealth, technological development, and relative peace in the European context—often referred to as “La Belle Époque”—it also produced a third wave of bubonic plague infection that manifested primarily in the colonial context and among the colonized.

The maritime pathways of economic exchange upon which empires depended also served as the mechanisms through which this third wave of bubonic plague spread around the world. Despite its global reach, the third wave of bubonic plague is often relegated to a historical footnote alongside a teleological narrative of progress relative to the rise of the bacteriology, disease control, and international health protocol. As Echenberg (2007) notes, this is due to the fact that these outbreaks did not reach European shores, a key facet of the broader response to plague at this time. It is worth noting here whose lives and which pandemics are worthy of social and historical consideration, during the 19th century and today.

The third wave of bubonic plague infections originated in East Asia, spreading from the British colony of Hong Kong in 1894 to port cities around the world. Due to its role as a central node in the maritime trade networks that sustained the British Empire, the city of Cape Town fell prey to an outbreak of bubonic plague in 1900. The pathogen entered a society engulfed by a colonial war; the South African War, which lasted from 1898–1902, centered on control of the mineral wealth in the Afrikaner republics to the north, which held some of the world’s largest gold deposits. The conflict between the British Empire and the Afrikaner settler states is perhaps best known for the British utilization of concentration camps to undermine Afrikaner resistance. However, the conflict also led many to migrate to coastal cities such as Cape Town, Port Elizabeth, and Durban, increasing population density in these port cities as bubonic plague wound its way around the globe.

Maynard Swanson (1977) has provided the authoritative account of Cape Town’s plague outbreak at the turn of the century. Swanson’s primary aim in constructing this historical account is to highlight how the public health response to bubonic plague concretized racial segregation in urban areas, which served as a template for subsequent policies that divided the South African population along racial lines, such as those associated with apartheid. Here, I will utilize Swanson’s historical account to analyze the state response to the epidemic, highlighting the relationship between race, class, and the deployment of state violence in the face of a deadly pathogen.

The colonial response to bubonic plague in Cape Town is one that highlights how preconceived notions of race informed a governmental response to an infectious disease outbreak. Notably, the response from Cape Colony administrators focused on infections among Black South Africans rather than utilizing scientific observation of disease prevalence. The colonial state forcibly removed Black South Africans from central areas of the city, burning their homes and belongings under the logic of disease control. Here, it should be noted that there were a higher number of people infected with plague among both the European and ‘Coloured’ populations in Cape Town, but that a similar response was not mounted relative to the lives and livelihoods of these racially defined populations (Swanson, 1977, p. 393). The focused violence on Cape Town’s Black South African residents reflects the development of the colonial state as a mechanism for enacting violence towards colonized people.

The location to which Black South African residents were forcibly removed is worth discussing further. The displacement of Black South Africans from urban centers placed them into social contexts that increased their risk of exposure to infectious disease. In this case, the establishment of Uitvlugt, later renamed Ndabeni, next to a sewerage farm increased the risk of contaminated water supplies, which can lead to diarrheal disease and parasitic infections such as hookworm. The high population density of this early township was apparent from an early phase, with 7,000 Black South Africans resettled from across Cape Town into Ndabeni (Maylam, 1990). The socio-spatial density of this—and other—early townships would later serve to amplify the spread of tuberculosis as the pathogen spread from the mines, to rural areas, and later to urban townships across South Africa (Packard, 1989).

A similar pattern of disease response is observed by Howard Phillips (2014) relative to a linked outbreak of pneumonic plague in Johannesburg in 1904. However, in this case the population initially targeted by the state for forced removal from the city center were Indian residents. In analyzing this case study, Phillips builds on Swanson’s account, focusing on the role of state medical authorities in the development of racial segregation in South Africa’s urban centers. Coming on the heels of outbreaks in Cape Town and Port Elizabeth, plague in Johannesburg was met by responses that highlight the modes of state power directed towards non-white South Africans.

Medical authorities advocated for the wholesale burning of the predominately Indian areas where plague had broken out, with some advocating that the settlement be “wired in and burned with its inhabitants” (Phillips, 2014, p. 316). Here, the role of medical authorities in advocating a necropolitical state response towards South African communities of color is unmistakable. However, it should also be noted that state medical authorities approached the public health response to plague in Johannesburg with clear ideas of their desired outcome: the spatial division of the urban population into race-based categories. The forced removals began with Indian residents, but soon expanded to include Black South African residents of areas that had not experienced plague. Indeed, a clear plan of forced removal and selective destruction of property focused on communities of color in Johannesburg, with a city councilor subsequently characterizing the plague outbreak as a “blessing in disguise” for the ends which it had enabled (Phillips, 2014, p. 324).

As the plague outbreak dissipated in Johannesburg, the state response continued to manifest along racial lines but exhibited significant differences relative to the Indian and Black South African populations. At this time, Indian civil rights activist Mahatma Gandhi resided in South Africa and played a significant role in negotiating with the colonial state regarding the displacement of the Indian community and destruction of their property under the aegis of public health. Gandhi argued that, in the absence of a public health emergency, the South African state had no legal basis for enforcing a residential ban towards Indians inhabiting particular neighborhoods (Phillips, 2014, p. 329). Further, Gandhi underscored that if the colonial state continued with this approach, that the Indian government would be alerted to the situation, which would likely cause the British Parliament to call for the ban to be revoked. Here, it is necessary to note that Gandhi’s progressive politics were limited to Indian South Africans and that, according to Desai and Vahed (2015), he had internalized racist, imperial visions of human ancestry that rationalized segregation, apartheid, and racialized violence.

The Black South African residents forcibly removed from their neighborhoods did not have recourse to political stratagems that manipulated intra-imperial power dynamics in their favor. Despite not having served as the locus of plague infection, Black South African communities were forcibly moved to an area that had recently been acquired by the government and was located far from the city center: Klipspruit Farm. Notably, the farm was already under use by the city at the time it was designated as a resettlement area for Black urban residents—it was utilized as a sewerage farm. While the displaced Indian community gradually moved back into the Johannesburg city center, the Black South African population remained displaced at the urban periphery amid environmental conditions that ensured adverse health outcomes.

The transnational spread of bubonic plague’s third wave into South Africa highlights that in both Cape Town and Johannesburg, preconceived notions of race informed state responses to plague rather than empirical evidence. Despite experiencing fewer infections than other groups, the population that was most deeply affected in both cases was Black South Africans. The deployment of the state’s capacity for violence towards Black communities highlights a point of clear continuity between the early and late colonial periods in South Africa. In addition to the dynamics of race and state violence, this example also highlights active resistance to these dynamics from poor and working-class communities of color in colonial South Africa. While the Indian community in Johannesburg was able to rely on Gandhi’s transnationally focused intervention, Black South Africans displaced to Ndabeni in Cape Town had to resort to more direct tactics against various forms of state violence.

Following their forcible removal to Ndabeni, Black South African residents confronted environmental conditions that undermined their health and a state that sought to recover costs on the heels of the response to plague outbreaks (Swanson, 1977, p. 397). The state sought to extract rent from the displaced residents to Ndabeni—an early example of the “cost-recovery” schemes that have figured prominently in both structural adjustment programs and recent austerity regimes (Powers & Rakopoulos, 2019). Similar measures were adopted following an outbreak of plague in East London, with the colonial state setting the monthly housing costs in resettled areas at a level equal to what Black urban residents had paid annually, or a twelve-fold increase. This massive increase in living costs was rationalized based on cost-recovery or making the Black urban community “pay its way” for a settlement that it had no desire to reside within (Swanson, 1977, pp. 403-404). In Ndabeni, the Black South African community actively resisted these ends with “riots”—or spontaneous acts of resistance against state violence—one manifestation of their response to the linked dynamics of necropolitical violence and public health.

Here, it is also important to note the contours of care that existed during the colonial era in South Africa and across the colonized world. While the positive effects of Western biomedicine were deployed as a mechanism for rationalizing

empire, access to health care for the colonized was often quite limited in practice. Indeed, as Packard (2000) notes, across the colonized world curative care was focused on maintaining the health of European populations rather than colonized peoples. This was the case in colonial South Africa, with hospitals predominantly built in urban centers that focused on the needs of European settlers while Black South Africans were concentrated into rural reserves that were insufficient to sustain the population, leading to chronic undernutrition and infectious disease epidemics, including tuberculosis, syphilis, and later, HIV/AIDS. As Mamdani (1996) underscores, colonized peoples were predominantly categorized as subjects rather than citizens. The entailment of this narrow definition of who constituted “the public” had clear implications for colonial health responses to infectious disease outbreaks, displacement, and the violence that accompanied these processes.

3 COVID-19, Lockdown, and Precarity in Post-Apartheid South Africa

The first positive test case of COVID-19 in South Africa was announced on March 5, 2020 and was traced back to wealthy white residents of the port city of Durban arriving back from a skiing holiday in Italy. The introduction of a new and deadly pathogen was met with trepidation in South Africa, a society that has spent decades fighting against the world’s largest HIV/AIDS epidemic. In a society where tuberculosis and HIV/AIDS synergistically interact to increase mortality and disease prevalence, the emergence of another pandemic offered new possibilities for syndemic infection (Singer, 2009), particularly among poor and working-class communities across South Africa. The specter of uncontrolled infection within South Africa’s peri-urban townships animated debates on how best to address an emergent pandemic that carried with it the possibility of significant mortality in South Africa and other post-colonial societies across the global south.

As infections began to spread throughout the country, the ruling ANC announced that stringent measures would be put into place to prevent the growth of the COVID-19 epidemic. South Africa’s lockdown limited work-related travel to essential care providers and enacted severe restrictions on social mobility, including leisure activities such as jogging and dog-walking and a ban on sales of alcohol and cigarettes. Heavy fines were to be imposed on those who broke the law during this time (BBC, 2020a). As noted above, the adoption of this authoritarian public health response was accompanied by acts of lethal violence carried out by South African security forces, which focused on residents of Black urban communities.

Despite the severity of South Africa’s lockdown, COVID-19 infections continued to grow across the country. By mid-July, South Africa had reached 276,200 confirmed cases, which led the ANC to adopt a measure enforcing the use of masks in public places (Haffajee, 2020). By August 1st, South Africa had surpassed 500,000 cases of COVID-19 and reported 8,153 deaths (BBC, 2020b). However, according to researchers from South Africa’s Medical Research Council (MRC) these numbers did not reflect the full impact of the pandemic. Indeed, critiques quickly emerged that official statistics “dramatically under-reported” the impact of COVID-19, with 59% more deaths from natural causes registered and some provinces projected to have 10 times more COVID-19 deaths than what had been reported (Paton, 2020). While many had feared that the first wave of COVID-19 would be far more severe, in addition to lethal state violence, South Africa’s lockdown brought economic dislocation to historically disenfranchised Black communities across the country.

In a society where 0.01% of the adult population controls 15% of total wealth and the top 20% controls 68% of income, it did not take long for the economic impact of South Africa’s COVID-19 lockdown to take hold (Chatterjee et al., 2020; IMF, 2020). Indeed, the neoliberal policies adopted by the ANC during the post-apartheid era have not transformed racialized inequality or the socio-spatial racial segregation that are the legacies of colonization and apartheid. Given this unequal history, the HIV/AIDS and tuberculosis epidemics are concentrated in peri-urban townships and informal settlements, with infectious disease serving as one proxy measure for historical inequality. The impact of this history and the economic dislocation associated with the COVID-19 pandemic has been heavily gendered, with women working in the informal economy bearing the brunt of limited access to work. According to Rogan and Skinner (2020) “women in informal employment experienced a 49% reduction in working hours between February and April (from 35 to 18 hours) while men saw a 25% decrease over the same period (from 40 to 30 hours).” In a related matter, the number of households that ran out of money for food in April 2020 more than doubled compared to 2019 (Van de Berg et al., 2020;

Wills et al., 2020). The immediate impact on under-nutrition highlights the number of households living in precarious circumstances.

As the impact of lockdown hit South Africa's poor and working-class communities, many resorted to rationing food, skipping meals, and gathering wild plants for sustenance. Parents in particular reported going without food in order to prevent their children from starving, circumstances that were far from exceptional (Green, 2020). However, the looming threat of starvation also led some to access the resources necessary for survival through force, with grocery stores a prime target (Davis, 2020). The resort to desperate measures was a matter of weeks rather than months, with "food riots" occurring by mid-April. While the precarious social, economic, and material conditions that poor and working-class communities navigated highlight the racial inequalities that span South African history, they are also a reflection of the socio-economic policies that the ANC has adopted during the post-apartheid era.

Shortly after coming to power, austerity was implemented by the ANC during the late 1990s, marking a clear break with the party's earlier embrace of Marxist and Keynesian economic policies. Initially adopted amid a series of currency crises during the 1990s, austerity cut funding in real terms for social programs, including health services, to repay debts incurred during the apartheid era. While this was a national policy decision undertaken by the ANC, it was one that was heavily informed by the impact of global financial markets and the influence of the Washington Consensus. Policy principles associated with austerity have continued to circulate in South Africa beyond the period during which spending on health and other social programs were strictly controlled (1996–2003) in order to lower levels of national indebtedness.

However, during the post-apartheid era, the South African state has also extended state support via a set of social grants that send monthly stipends to 18.3 million people, or 31% of the population (BusinessTech, 2021). These income-based grants provide support to the elderly, children, and disabled, and were expanded as part of the COVID-19 response to include a Social Relief of Distress grant, which targeted those who did not already receive a social grant and without income for a monthly amount of R350 (approximately \$19) (Maeko & Mathe, 2020). This new grant was part of a broader series of measures adopted by the ANC, including a government stimulus that was framed as a R500 billion package (approximately \$30 billion) that aimed to expand both the social safety net and export-oriented economic growth alongside the lockdown. However, as Gqubule (2020) notes, the ANC's stimulus package largely maintained the "austerity budgets" that have been reintroduced in South Africa since 2013. Indeed, the "stimulus" reassigned funding from existing projects that aimed to improve infrastructure in impoverished areas, providing grants with one hand but withdrawing investment in the built environment with the other.

However, the ANC's COVID-19 stimulus plan also served as an opportunity for those in positions of power and influence to accumulate capital through various means. The allegations include the misappropriation of funds from the Unemployment Insurance Fund and the granting of government contracts for the provision of personal protective equipment (PPE) to relatives of state officials at inflated prices (Chutel, 2020). In the latter case, the estimated overcharge for PPE and other supplies necessary to fight COVID-19 was over R500 million (approximately \$26.9 million) (Myburgh, 2020). Clearly, significant resources were redirected away from those that needed them most amid the crisis.

The diversion of government funding has also impacted public health workers. With PPE at a premium, the public health sector was hit hard by COVID-19 infections. Public health facilities are often run with limited staffing due to neoliberal budgetary policies, a systemic issue inherited from the apartheid regime that has been exacerbated by post-apartheid fiscal austerity (Powers, 2019). This situation has been aggravated by the COVID-19 pandemic, with some facilities reporting up to 30% of their staff falling ill (Harding, 2020). In a society where historical inequalities and burdens of disease follow racially demarcated social and geographical patterns, restrictions on public health resources are particularly impactful in poor and working-class Black South African communities where the country's inequality is embodied via HIV/AIDS, tuberculosis, under-nutrition (Fassin, 2007)—and now, COVID-19.

One such community is the peri-urban township of Khayelitsha, located approximately 25 kilometers outside of Cape Town's city center. The township, whose population has been estimated at up to one million residents, has been deeply impacted by the HIV/AIDS epidemic over the last three decades and, prior to that, faced a tuberculosis epidemic. While the township has seen the expansion of clinical infrastructure since the negotiated transition out of apartheid, significant and ongoing staffing shortages have undermined public health workers' ability to address both infectious and non-communicable disease in Khayelitsha. One strategy that has been employed to address chronic human resource shortages in the public health sector has been to expand the role of community health workers.

As COVID-19 has spread across South African society, community health workers (CHWs) are among those who have borne the brunt of the increased workload associated with the pandemic. This is due in part to the role that CHWs play in a health system, in which they serve as an extension of the primary care clinic by carrying out tasks that can include home visits, delivery of medicines, and other tasks that ensure that people are not “lost to follow up”. During the COVID-19 pandemic, CHWs working in Khayelitsha were instructed to increase the number of home visits they carry out with limited access to PPE (Nocuze, 2020). However, it is important to note that most CHWs are facing increased risk of exposure to COVID-19 while lacking formal employment status.

In the South African public health sector, CHWs are not formally employed by the state, but hired through NGOs that are supported in part through government grants. This arrangement enables a “flexible” labor structure whereby CHWs are paid small stipends on rolling contracts, but these workers lack the labor protections extended to formal public sector employees (Hlatshwayo, 2018). CHWs have carried out protests across South Africa to demand formal sector employment in response to their work conditions amid the COVID-19 pandemic (Ellis, 2020). There have also been successful campaigns on this issue, as CHWs were incorporated into the public health system in Gauteng province in response to these actions. CHWs have been far from alone in their critical response to the ANC’s lockdown policy and its concomitant effects on South African society. South African trade union the National Education, Health and Allied Workers’ Union (Nehawu) also threatened to go on strike due to the significant impact of COVID-19 on healthcare workers. According to Nehawu General Secretary Zola Saphetha “We are dying now. We are burying our members” (Nicholsen, 2020).

In response to the social effects of COVID-19, an alliance of civil society organizations united together to fight the pandemic under the aegis of the C19 People’s Coalition. Uniting organizations from communities infected and affected by the pandemic across South African society, the C19 People’s Coalition includes community organizations, trade unions, social movements, and health workers, to name but a few. The Coalition advocates for a bottom-up approach to fighting the pandemic, and for the provision of essential services to meet basic needs. In addition, Section 27, formerly named the Aids Law Project, and the social justice-oriented NGO Equal Education successfully launched a legal challenge against government policy that suspended school feeding programs amid the lockdown (Veriava & Stevenson, 2020). These NGOs have continued to monitor government implementation of school feeding schemes following the legal precedent set by their campaign. Another area where organizations directly tied to the HIV/AIDS movement have confronted the spread of COVID-19 is contact tracing. HIV/AIDS activists working with international NGO Médecins sans Frontières (MSF) have worked on the front lines of disease prevention, carrying out contact tracing in Khayelitsha, for example. However, not all social responses have followed the human rights and public systems strengthening approach associated with the South African HIV/AIDS movement.

As the South African state has exercised violence towards poor and working-class Black communities via its authoritarian COVID-19 response, people have responded in kind. For example, the state-mandated demolition of an informal settlement in the Makhaza area of Khayelitsha destroyed homes, personal property, and livelihoods amid the pandemic. In response, residents of this area protested state violence and subsequently destroyed public goods in the form of a newly constructed health facility and the Desmond Tutu Community Hall (Lali, 2020). The closure of formal channels for substantive political participation amid authoritarian violence and post-apartheid austerity appears to have left the poor with few outlets to have their voices heard in post-apartheid South Africa. On this point, the broader economic constraints that South Africans face alongside the COVID-19 pandemic are worthy of further consideration.

The ANC has sought to ameliorate the conditions of South Africa’s historically marginalized Black population but has done so within the constraints of neoliberal macroeconomic policies that were initially put into place during the mid 1990s. As Isaacs (2020) notes, this contradiction lies at the core of why the ANC’s COVID-19 stimulus package has failed to limit social suffering. The contradictory and simultaneous modalities of government support and neoliberal austerity also manifest relative to the country’s social grants programs. As Bond (2020) underscores, monthly state support for mothers raising children has fallen from \$38 during apartheid to \$24 today. Further, the provision of state support to address the COVID-19 pandemic was accompanied by a \$250 million cut to the national health budget—one of several budget cuts designed to limit the impact of pandemic-related spending on national credit ratings. Indeed, it is significant to note that COVID-19-related government spending constitutes just 0.1% of South Africa’s GDP, a number that helps contextualize why under-nutrition and social suffering have expanded so rapidly alongside the pandemic and lockdown.

4 South Africa and the Necropolitical State: Tracing Continuity, Considering Limits

How then are we to make sense of the still-unfolding COVID-19 epidemic in South Africa relative to the outbreak of bubonic plague at the turn of the 20th century? What insights might be drawn from these two episodes of epidemic response relative to the modalities through which state power is exercised and citizenship experienced in South Africa? The discussion that follows below focuses on these questions, returning to the conceptual debates on sovereignty, necropolitics, and citizenship raised in the introductory section of this paper.

As the review of South Africa's bubonic plague outbreak highlights, state violence has been exercised differentially relative to racially defined populations since colonial settlement, an important continuity that is reinforced by the state response to COVID-19. However, the deployment of the state's capacity for necropolitical violence has varied in both degree and scale. The colonial wars of conquest that manifested across four centuries operated at a far larger scale and had far more impact in terms of death. The colonial technologies of domination included, but were not limited to, fatal violence, dispossession, and the spatial concentration of the Black South African population into rural reserves and racially defined peri-urban townships. As a key moment in the development of racial segregation in urban areas, state responses to bubonic plague outbreaks played a central role in producing this spatial division of the South African population between colonizer and colonized—between white and non-white. That these forms of spatial segregation, material deprivation and racialized inequality continue underscores that the fundamental contours of violence must include the socio-spatial dynamics of South African society and the social determinants of health that they produce. Mbembe's insights relative to necropolitical historical continuities loom large here.

The comparative exercise between the state responses to bubonic plague and COVID-19 also provides insight into the dynamics of continuity and disjuncture relative to citizenship rights in South Africa. In thinking through the experience of citizenship rights during each of these infectious disease outbreaks, I build on Berlin's (1969) conception of positive and negative liberties. Briefly, negative liberties are associated with civil and political rights and refer to the right to certain protections, such as safeguards from religious persecution, violence, etc. Positive liberties are associated with socio-economic rights, understood as the right to certain things such as health, water, work, etc. Here, I analyze the dynamics of citizenship within the two case studies based upon this dualistic conceptualization of human rights, tracing difference and continuity across time.

Relative to negative liberties, there is a clear line of continuity that can be observed between the state responses to bubonic plague during the colonial era and to COVID-19 during the post-apartheid period. Despite having been made full citizens of the country under the 1996 constitution, it appears that Black South Africans still lack protection from state violence. Thus, while Black South Africans have the *de jure* right to life and liberty, the necropolitical modalities of state power that continue to be exercised in post-apartheid South Africa underscore that these negative liberties do not necessarily hold amid the *de facto* realities of everyday life. These dynamics highlight Mahmood Mamdani's (1996) key insight—that a form of tiered citizenship has existed in South Africa since the colonial era, which continues to be practiced in rural areas under the political authority of traditional leaders. While the post-apartheid constitution has expanded the domain of rights-bearing individuals to include Black South Africans, the COVID-19 pandemic raises the question of whether the negative liberties that Black South Africans fought for over three centuries to secure are actionable in everyday life.

Relative to the consideration of positive liberties, these too were limited for non-white populations during earlier historical periods. As G'sell (2020) notes, the social welfare provisions that were provided to non-white mothers during the apartheid era were far more limited. Thus, while the colonial and apartheid states did provide limited social welfare provisions for non-white populations, these were not tied to formal citizenship status during these earlier periods. However, the 1996 constitution includes an entire section that focuses on socio-economic rights. The formalization of positive liberties in the post-apartheid constitution has produced significant points of disjuncture that must be considered in assessing the post-apartheid state and the modalities of power employed towards the South African population.

During the post-colonial era, the ANC has expanded social grants programs to support more of those in need of material support, including mothers, children, and the elderly. The post-apartheid state has also been pressured by social movements to expand the limits to social support. In particular, the South African HIV/AIDS movement exerted

significant pressure on the state to protect the right to health for people living with HIV/AIDS by providing HIV/AIDS treatment access. While these programs have been limited due to the impact of neoliberal macroeconomic policies adopted by the ANC, they represent the expansion of a state modality that sustains life (Powers, 2020). This marks a significant point of historical divergence given that these programs have largely transferred state resources that maintain livelihoods and health to the historically disenfranchised Black South African population. While insufficient to meet the socio-economic and related health needs of South African society, the development of state capacities to support the poor and working class across racial lines can also be seen with expansion of social grants as part of the COVID-19 response.

The COVID-19 pandemic also sheds light on the combined effects of expanding social programs based on socio-economic rights while maintaining a neoliberal approach to economic matters. While Isaacs notes that this contradiction has been exacerbated by the COVID-19 pandemic, the historical foundations of these socio-economic practices are worth further consideration. Neoliberal socio-economic policies can be traced back to liberal economic thought, which itself emerged in the context of Anglo-European imperialism and informed the political and economic contours of colonization. As noted above, the colonial period in South Africa was one during which Black South Africans were exposed to lethal state violence and had stringently limited access to citizenship rights. This raises the question of how liberal socio-economic ideals, which reflected—and served as the underlying framework for—imperialism, have been translated into neoliberal policy in post-apartheid South Africa. Further, the contradictions exposed by the COVID-19 pandemic lead us to question whether political and economic theories that were predicated on resource extraction and limiting the domain of citizenship to Anglo-European settler populations can co-exist with the modalities of state power that have emerged during the post-apartheid era and seek to redistribute resources to poor and working class Black South African communities.

5 The Portal, (Neo)Liberalism, and the Necropolitical State

This paper opened by engaging with Arundhati Roy's invitation to imagine the COVID-19 pandemic as a portal to a new world, and built on this conceptualization to expand Roy's proposal and turn the portal to the past, examining the continuities and ruptures emanating from an earlier episode of infectious disease response. Relative to the South African case, using the portal to examine the past underscores that there are important parallels with the modes of state violence and lived experience of citizenship that accompanied the public health response to two infectious disease outbreaks that occurred over a century apart. There are also important instances of disjuncture, where existent historical trajectories are redirected by social movements and the incorporation of social and political principles into the state that expand forms of care and support beyond the racial divisions that have defined South African history. However, the use of Arundhati's portal highlights another thread that winds its way through the case studies and is worthy of brief mention here, and that is the circulation of economic theory and practice, the contemporary nomenclature deployed to engage with these dynamics, and the potential productivity of further historical contextualization of (neo)liberal social, political, and economic practices.

Here, I have traced necropolitical violence as a modality of state power across space and time through the examination of two infectious disease outbreaks. Relative to state responses to both plague and COVID-19, the (neo) liberal economic principle of cost-recovery manifests, but in different ways. The state health response to plague during the colonial era manifested through a violent process of forced removals, the development of "new" locations, and the imposition of fees associated with everyday life in the new, state-mandated locations. Notably, in the colonial context these dynamics were also associated with moving Black South Africans to locations with environmental conditions that compromised health, in this case sewerage farms. Relative to the COVID-19 pandemic, the South African state has extended social grants to historically marginalized populations, expanding existing state capabilities to provide care and marking a clear break with past expressions of state power. However, there are also clear examples of cost-recovery measures that have accompanied the COVID19 response, such as significant budgets cuts for public health and for data collection on poverty and inequality. On this point, we should note that this paper is being written while the pandemic continues to infect and kill people in South Africa, and that the debts being incurred by the South African

state foreshadow a future where cost-recovery and austerity are likely to be introduced to repay them. Critically, such measures would continue a pattern observed during the post-apartheid era, as noted above.

The continuities here between the colonial era and the present invite us to think more about the use of the term neoliberal, which has become commonplace in academic circles over the past three decades. The term neoliberalism has primarily been used to highlight continuities in economic thought between the 19th century and the present, with a particular emphasis on the expanding role of markets in society. According to this line of analysis, markets that had been regulated during the 20th century during a period of national capitalism were gradually deregulated, leading to an expansion of transnational economic activity, the rise of global financial markets, and increasing social, political, and economic inequality (Harvey, 2005). However, it is less often the case that these analyses of continuity in economic thought and practice engage with the political context and modes of state power that informed the emergence of liberal economic thought in the 18th and 19th centuries. On this point, it would be productive to engage more critically with the question of historical context as a set of social, political, and economic dynamics that do not simply frame our contemporary understanding of (neo)liberal economic theory, but were productive of these ideas and reflected the social, political, and economic processes of this time.

As the examples of state responses to infectious disease outbreaks described above indicate, state policy responses rarely unfold based on public health considerations alone. Rather, they reflect social inequalities, economic processes, and power relations that leave Black South African urban communities facing precarious socio-economic conditions and lethal state violence. Thus, looking through Roy's portal thus invites us to consider how the reanimation of liberal economic ideals in the late 20th century resuscitates particular socio-economic dynamics both within and across societies, encouraging us to consider further contextualization of the array of state modalities associated with the neoliberal era with that of imperial polities. Indeed, analyses of state violence and the capacity of the state to kill might consider how political decision-making that produces human death also invokes economic thought and principles that originated during the era of Anglo-European imperialism.

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