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'On paper' and 'having papers': migrants navigating medical xenophobia and obstetric rights in South Africa

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By Tamuka Chekero and Fiona C. Ross

> *Chekero met Pauline at a local pharmacy in Giyani, a small town in the north-east of the Limpopo Province of South Africa. The area is best known to foreigners as being close to the famous Kruger National Park, a tourist hotspot famous for 'the Big Five' game to which it is home. It is also an important receiving town for migrants[1] from neighbouring Zimbabwe and Mozambique, many of whom have left their birthplaces to seek economic and political refuge. In the course of conversation, Pauline described her experience of having been 'prescribed' a caesarean section in 2016. She argued that the c-section would have been medically unnecessary but had been 'prescribed' solely because she could not produce 'papers' (identity documents or refugee papers) that indicated her right to be in South Africa. She said that she went to the local state hospital when her labour began. She was asked to produce identification papers, which she did not have. She waited five hours to be attended to and recalled that practitioners seemed reluctant, attending her only after they had served all other patients who seemed to be citizens. They seemed to be exhausted and ready to leave work, she recalled angrily. They admitted her into the labour room. Having ascertained that she was Zimbabwean, immediately, and without proper procedure and examination, she said, they 'prescribed' her a caesarean section. She pleaded with practitioners to wait. She had already born one child 'naturally' (i.e. vaginally) and was unclear about why the c-section was being proposed. In the midst of deliberations, her baby could not wait any longer and she bore to a 'bouncing baby boy' through vaginal birth.*

Pauline and others read the medical insistence on 'c-section' birth as a sign of bias against 'foreigners'. While the medical reasons for prescribing a c-section in Pauline's case are not known, what matters for our discussion is that there is a widespread perception among migrants that state officials perform unnecessary c-sections on migrant women; that

is, that the South African state is routinely involved in obstetric violence against migrants despite its commitments and legal obligations to supporting pregnant women, mothers and infants. Many Zimbabwean nationals among whom in South Africa both on this project and in Chekero's earlier work with the Treatment Action Campaign (TAC 2013-14) shared similar stories of the medical exclusions and routinized humiliations they recurrently encountered in trying to access public health facilities in South Africa, especially when they were 'without papers'.

A recent controversial news report that did the rounds on social and national news media affirmed migrants' beliefs. In June 2017, the Zimbabwean internet newspaper IHarare reported that Francine Ngalula Kalala, a woman from DRC, gave birth on a train at Park Station in the Johannesburg CBD after having been turned away from three hospitals because she was a foreigner (IHarare 2017/06/05, accessed 5 June 2017)[2]. Responding to the article, which had quickly reached a wide audience, authorities from the Gauteng Health Department said Kalala was not denied access but that she had refused medical advice to have a c-section. The fact that the Francine birthed vaginally, unattended by medical professionals although she had been prescribed a c-section confirmed migrants' fears that the state authorised unnecessary surgical interventions. That the Minister of Health made a statement about this event and ordered an investigation did little to assuage their concerns. There is a growing body of evidence that demonstrates high rates of abuse in medical birthing settings in South Africa in both public and private institutions (see Chadwick 2016). Migrants' beliefs are formed and claims are made against this medical backdrop and in a context in which migrant rights are often undermined, both by host communities and by the state. Crush and Tawodzera (2014: 1) describe the 'negative attitudes and practices of health professionals and employees towards migrants and refugees' as 'medical xenophobia'.

Shuvai, for example, described the hostile reception she received in state hospitals when she was able to access them. She reported having been denied treatment when she could not produce papers identifying her as legally entitled to be in South Africa. When she was successful in accessing health care, she described professional staff as being hostile. She was verbally attacked and called derogatory names like *Makwerekwere*[3] or "border jumpers". Nurses described Zimbabweans as 'people that bring diseases to South Africa', 'flood hospitals' and 'exhaust medications'. Shuvai was shocked. She anticipated that medical professionals would offer care not disparagement and rejection. She noted that her experiences of medical attention were considerably worse than that offered to South African citizens whom she met in these institutions. The accusations she reports – that 'foreigners' 'exhaust resources' and 'bring diseases' – are widespread in South Africa. Crush and Tawodzera

(ibid) cite data from a nationally representative survey by the Southern African Migration Programme (SAMP, 2006) which demonstrates that two thirds of South African nationals sampled for the study hold this perception of migrants. Migrant women frequently described experiences similar to Shuvai's, confirming Crush and Tawodzera's argument that medical xenophobia is rampant in the South African public health facilities.

On paper, that is, in terms of legislation and international protocols to which South Africa is a signatory, pregnant migrants are legally entitled to free reproductive health care and to free primary care for their children under six. [4] For example, the Section 27 (1 a) of the Constitution of the Republic of South Africa, Act 108 of 1996, states that everyone has the right to have access health care services, including reproductive health care. South Africa is a signatory to the United Nations (UN) Strategic Development Goals (SDGs) (IOM, 2014). These obligate member states to address the health needs of women and children. South Africa is also committed to the resolution on health of migrants adopted during the World Health Assembly (WHA) in May 2008 (IOM, above). It calls upon member states to promote equitable access to health promotion and care for migrants. Antenatal care, routine infant check-ups, specified vaccinations and family planning treatment including HIV and STD are all covered in this care. Despite awareness that 'healthy migration is good for development' (Vearey, 2014: 663), in practice, many migrants confront state officials whose attitudes may be actively anti-(im)migrant, and whose actions may range from offering excellent care to complete neglect and refusal of care. Migrants quickly learn that possessing 'the right papers' is critical in accessing the state health care sector, even though such papers are not required in law for migrants to access reproductive health care.

Globally, migrant rights are increasingly being rolled back. HRW (2009) notes that most migrants have found themselves with limited or without basic human rights fundamental to life: food, shelter, physical security, and access to basic health care. Migrants feel that their rights can be suspended or debased at any time (Mbembe, 2017). Zimbabwean migrants in Giyani are familiar with the list of exclusions described by HRW above. Having arrived in South Africa to escape political persecution and/or to find ways to survive and support family 'back home' in the midst of Zimbabwe's massive economic decline and hyperinflationary environment of the last decade, migrants find themselves constantly at risk of exposure. Indeed, for most Zimbabwean migrants, remaining in South Africa is becoming increasingly procedural. The police regularly put up spontaneous roadblocks to stop vehicles and arrest those who lack 'papers'. The result is to restrain the mobility of migrant women, who frequently told stories about being ill but afraid to access health facilities for fear of arrest en route. Mbembe (2017) shows how such scenarios

build on a long history of regulation and restriction of migrants, arguing that we should see this as the ongoing militarization and contraction of local borders and tightening of rights. Beyond their fear of arrest and deportation, migrants also expressed fear of being publicly outed as 'foreigners' at times when xenophobic tensions in the area were heightened. Given the horrifying violence against African migrants in May 2008, a series of events that remain fresh in memory, people are guarded about being too openly identified as non-nationals.

Although 'on paper', migrant women have enforceable rights independent of their legal status in South Africa, in practice, 'having papers' is essential to accessing state health care. While South African law regarding migrants and immigrants of various kinds has been identified as among the most liberal in the world, in recent years, borders have been tightened and there is increasing bureaucratisation and surveillance of migrants.[5] Suffice it to say that there are a range of strategies for crossing borders and remaining in South Africa. Most migrants among whom research was undertaken in 2016 and 2017 in Giyani had passports but their entry / residence visas were invalid. Unlike during an earlier period of relatively liberal access to documentation, most people now enter on a free 30 day entrance visa issued at the border. Some enter and exit Zimbabwe regularly to keep their visas current, some bribe customs officials to grant longer visas, some return to Zimbabwe to have their passports stamped 'returned' and then slip back across the border into South Africa. As a result they are legally in Zimbabwe while actually in South Africa. Their reasons for this complex subterfuge are simple. Zimbabwe's economy collapsed and has not fully recovered. Many people seek work in South Africa in order to live and to send money home. Survival is at stake. Their encounters with bureaucracy suggest the fractal nature of state power (Mbembe 2017), in which the arrangements at one level of encounters with the state (such as at national borders) are replicated in miniature at other state institutions (such as public health facilities).

An official from ANOVA, an NGO providing biomedical services in Giyani, confirmed that lack of 'papers' limits migrants' access to public health care, noting also that the state has made little effort to address migrant exclusions. Even where migrants know that they have rights to access health care they are not able to exercise them. He confirmed the accounts offered by my interlocutors, stating that there have been many cases at Nkhensani, the biggest hospital in Giyani, where health care practitioners deliberately deny migrants access to health services solely because they lack papers (see also Makandwa & Vearey, 2017; Kruger and Schoombee, 2010; Khalil, 2009). He noted that the key culprits here were those in 'small positions of power' such as the security guards or nurses. Observing that local NGOs such as ANOVA and TAC were keeping

records of medical failures, especially relating to obstetric care, he commented,

Sometimes migrant women, especially the pregnant [women], are not attended to or they are given student nurses to attend them which [is] risky because of their lack of experience. The challenges migrant women are facing are management oversight where the administration is failing practical policy implementation on ground.

Such episodes of medical exclusion and the hostile reception of female patients are suggestive of Chabal's notion of calculated violence; "the deliberate failure of government and state officials to discharge their duties" (Chabal 2009:153). The effect is to worsen the health shocks and risks experienced by migrant women especially those who are pregnant or with small children. Such health risks and shocks, which come atop the already complex and often traumatic experience of border crossings and residence in South Africa, compound the complexity of migrants efforts to 'make live' and suggest that the state is not always a willing partner in this biopolitics of life.

When medical exclusion impedes care, migrant patients tend to be diagnosed or treated late or not treated at all. Some may opt for privatised care, well into the development of illness, often when they are sicker. Care in this scenario is more expensive and treatment tends to be less effective. Private health care is costly; a GP visit costs between R350 and R450 (approximately USD 25-30). But private care is not the only option. Women migrants develop other strategies to obtain the treatment and medicines they may require. One of these is to make use of already existing networks, particularly those in local churches. Here, drawing on the social solidarities that churches generate and on the networks that their members hold, migrants are able to bypass some of the strictures of access to state resources. During one focus group discussion, women described health care practitioners who are compelled by the social obligations of relationships and the authority of pastors, to assist people whom, in other contexts, they might deny access to treatment. For example, some women said:

> *"Because we know that we have nurses in our church we can make use of their services. When we get sick we just call the pastor. The pastor will call the nurse to come and help. The pastor is respected and no one is bound to question his request."*

Other women described cultivating relationships with host communities through churches and shared everyday activities. They couched this work in the socialities of everyday life in the *chiShona* idiom of *hushamwari* or

husahwira. This relationship is more than 'mere friendship': it describes a close, carefully cultivated bond based on mutual recognition, respect and assistance. A woman named Madhuve, for example, described how her adoption of key symbolic elements of local dress – the *xibelani* – had attracted the attention of a Tsonga-speaking nurse, who approved of this attempt at cultural assimilation. They struck up a connection that has helped Madhuve access medications via the nurse from the state institution that had denied her access. The nurse runs great risks in doing this: technically, her access to and distribution of state resources outside of state institutions is illegal.

Migrant women described these networks as 'vital connections', intending to convey the critically important nature of such relationships. We draw attention here to the second of term's meanings: the links are vital in that they are nourished and nourishing, creating sets of relationships that draw on and bypass the state and enable the endurance of life itself. Drawing on Francis Nyamnjoh's work (2015) on the significance of conviviality for what he calls 'frontier Africans', and Ross's formulation of a hyphenated version – con-viviality[6] that seeks to emphasise the alertness to contingency that shapes everyday life for many, we argue that it is important to recognise the ways that living together can be productive of life somewhat independent – and partially in defiance of – some aspects of how the state operates.

Conclusion

We have shown that what is clear 'on paper' becomes considerably more opaque when experienced by those who do not 'have papers'. In the context of the radical decline in life possibilities in Zimbabwe, migrants seek means to sustain themselves and their families through networks in South Africa. While South African health policy is very progressive regarding migrant rights, particularly in its natalist stance, the research demonstrates that state institutions – even those that are legally obliged to provide services to migrants or at least not to discriminate against them – are considerably less welcoming than the legal frameworks within which health care is delivered suggests. Medical staff read the lack of papers as a sign of not-belonging and thence of exclusion from entitlements. Their responses vary from neglect to outright hostility. Forms of medical xenophobia proliferate. These are apparent in the treatment migrants report. It is also observed in their fears and the powers that inform them – of being unable to access health care; of unnecessary c-sections; of guards who refuse access to institutions to which migrants have rights. Migrants experiences are shaped by refusals and rumours. These difficulties are compounded by the ways that migrants slip beneath

regimes of visibility as they seek to go about their everyday lives unhindered by the state.

The result is twofold. One, migrant women who are entitled to public health care are unable to access it and may have to make use of private health care, despite the costs. Second, the same health care providers who have formally refused access to state institutions may be available to migrants through personal networks, such as those provided by membership in churches and through *hushamwari* relations. Here, we might see medical care as taking place in a religious and social register rather than a purely biomedical one. We suggest that the difference between what is 'on paper' and 'having papers' is critical but some instances can be mediated by access to other realms of the social.

Tamuka Chekero *is a Masters student in Anthropology at the University of Cape Town, where he is part of the research team in the Anthropology of the First Thousand Days. His work on migrant access to obstetric and reproductive health care builds on experience as a researcher for the Treatment Action Campaign in Limpopo Province, South Africa.* Fiona C. Ross *is Professor and Head of Anthropology at the University of Cape Town, where she holds an AW Mellon funded research chair and heads the research programme in The Anthropology of First Thousand Days.*

References

Amit, R. (2010). *Lost in the Vortex: Irregularities in the Detention and Deportation of Non-Nationals in South Africa. Report for FMSP*. Johannesburg: Wits University.

Chabal, P. (2009). *Africa: The Politics of Suffering and Smiling*. London: Zed Books

Chadwick, R. 2016. Obstetric violence in South Africa. *SAMJ*. Vol. 106, No. 5: 423-4.

Crush, J. and Tawodzera, G. (2014). "Medical Xenophobia and Zimbabwean Migrant Access to Public Health Services in South Africa" *Journal of Ethnic and Migration Studies* 40:65570.

Human Rights Watch. (2009). Zimbabwe: Events of 2008.

IOM. (2014). IOM Strategy Responds to Complex Migration Challenges in

Southern Africa.

Khalil, D. D. (2009). “Nurses’ Attitudes towards ‘Difficult’ and ‘Good’ Patients in Eight Public Hospitals.” *International Journal of Nursing Practice* 15 (5): 437–443. doi:10.1111/j.1440- 172X.2009.01771.x

Kruger, L.-M., and C. Schoombee. (2010). “The Other Side of Caring: Abuse in a South African Maternity Ward.” *Journal of Reproductive and Infant Psychology* 28 (1): 84–101. doi:10.1080/ 02646830903294979

Makandwa, T. & Vearey, J. (2017). Giving Birth in a Foreign Land: Exploring the Maternal Healthcare Experiences of Zimbabwean Migrant Women Living in Johannesburg, South Africa. *Urban Forum* 28: 75.

Mbembe, A. (2017). Scrap the borders that divide Africans. *Mail and Guardian*, March 17, 2017.

Morreira Shannon (2015). “You can’t Just Step from one place to Another”. The socio-politics of illegality in migration from Zimbabwe to South Africa. *Migration letters* 14:67-78

Morreira, Shannon. (2016). *Rights after Wrongs: Local Knowledge and Human Rights in Zimbabwe*. Stanford, CA: Stanford University Press, 2016.

Nyamnjoh, F. (2015). Incompleteness: Frontier Africa and the Currency of Conviviality. *Journal of Asian and African Studies*. Vol 52 (3): 253-270

Ross, F. C. (2015). Raw Life and Respectability: Poverty and Everyday Life in a Post-apartheid Community. *Current Anthropology*, Vol. 56, No. S11: S97-S107

Vearey, J. (2014). Healthy migration: A public health and development imperative for south(ern) Africa. *South African Medical Journal*, [S.l.], v. 104, n. 10, p. 663-664, Jul. 2014. doi:10.7196/SAMJ.8569.

Notes

[1] We use ‘migrants’ here to designate a broad category of non-citizens resident permanently or temporarily in South Africa. These may include people with formal refugee status, immigrants with legal rights to settle, those who have settled by crossing borders illegally, those who move between South Africa and Zimbabwe, and so on. If the legal category of migrant status matters, we designate this in the text.

[2] http://iharare.com/woman-gives-birth-in-train/. A google search on the woman's name

[3] Makwerekwere is a derogatory South African term for foreigners

[4] See also The National Health Act, section 4.3; The Refugee Act, section 27: summaries provided in a public announcement by Section 27: 'Access to health care for migrants' (20 June 2017), http://section27.org.za/2017/06/public-announcement-access-to-health-care-for-migrants/ accessed online 20 October 2017.

[5] It is beyond the purview of this article to describe the complexities of Home Affairs' management of (im)migrants, especially those from Zimbabwe. Interested readers are referred to Morreira 2015 and 2016 for details.

[6] Ross has developed the hyphenated term, describing con-viviality as 'an ethic that seeks to secure life, both life itself and "good life" as it is made through relationships. Used in this sense, con-viviality anticipates that being alive is at stake in social worlds and that it is accomplished alongside and through others. It does not necessarily anticipate peaceableness in or enjoyment of everyday relations … Rather, it extends a notion of alertness and liveliness to life's contingency. Con-viviality thus includes awareness of the limits of life making, including violence of many kinds—interpersonal, symbolic and structural (Ross, 2015: 100)

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