Probing the Context of Vulnerability: Zimbabwean Migrant Women's Experiences of Accessing Public Health Care in South Africa

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South Africa has a professed inclusive health policy that articulates that everyone is entitled to have access to health-care services, regardless of nationality and citizenship. However, several challenges exist for migrant women in South Africa, in accessing this health care. This paper, based on the experiences of Zimbabwean migrant women residing in Durban, focuses on their experiences of seeking and accessing health-care services in South Africa. Using a qualitative study design, semi-structured interviews were conducted with 22 purposively sampled female participants aged 25–49 years. This paper employs a structural-violence analysis to probe the underlying factors that make it challenging for Zimbabwean migrant women to access public health-care services in South Africa. The findings of this paper highlight that the lack of valid immigration documentation, often makes it challenging for participants to access services from public hospitals and clinics. The findings also reveal that the state of the South African public health-care system predisposes migrant women to health risks.

Keywords: gender, migration, health access, violence, South Africa

INTRODUCTION

The economic meltdown and worsening levels of poverty in Zimbabwe led to a significant increase in the number of women migrating to South Africa from 2005 to 2010 (Crush et al., 2015: 367). A Southern African Migration Programme (SAMP) survey in 1997 found that 61% of Zimbabwean migrants were male and 39% were female (Crush et al., 2015: 367). This suggested that there was an increase in the number of women migrating to South Africa compared with other countries in Southern Africa. This gives us reason to 'speculate' that the numbers could have increased a decade later because of the economic crisis that resulted in large numbers of people migrating out of Zimbabwe. Most Zimbabwean women are now moving across borders independently of their spouses and partners in search of better and sustainable livelihoods (Dzingirai et al., 2015: 13; Mbiyozo, 2019). Whilst some have valid immigration documents, a large number of these women are undocumented, which heightens their vulnerability to various structures of violence (Bloch, 2010; Rutherford, 2020: 172). Their migration pathways and experiences are distinctive from those of the men as they are more vulnerable to gender(ed) inequalities and pervasive violations. Migrant women are at a heightened risk of multiple forms of violence that include sexual and gender-based violence, exploitation, forced labor, and health vulnerabilities (see Sigsworth et al., 2008; Fuller, 2010; Von Kitzing, 2017; Mutambara and Maheshvari, 2019; Rutherford, 2020).

In spite of South Africa's constitutional provisions that everyone has the right to access health care, migrants and refugees encounter multiple challenges (Munyewende et al., 2011; Crush and Tawodzera, 2014). This paper aims to contribute to existing contentions on the challenges that migrants and refugees experience when accessing health care in South Africa. It particularly examines the extent to which underlying social and institutional factors of vulnerability make it challenging for Zimbabwean migrant women to access public health care in South Africa. The paper argues that when accessing public health care, migrant and refugee women are predisposed to various structures of violence that can easily be misconstrued as challenges that uniquely affect migrants and refugees only. The negative experiences of migrant women in public hospitals and clinics cannot all be attributed to their identity as foreigners. Instead, migrant and refugee women are also adversely affected by the 'crisis of care' that affects any patient (citizen or foreigner) using the public health-care system in South Africa.

CONTEXTUAL BACKGROUND

Health security and legislature

South Africa is one of the countries in the world that has some of the most progressive laws and policies regarding migrants and refugees (see Queue, 2015). However, the implementation of these policies has not been seamless and straightforward, and the Immigration Act of 2002 (RSA, 2002) contradicts the other overarching laws

that note that health-care facilities can assist undocumented migrants and refugees requiring treatment. Under the ambit of the United Nations Charter (UN, 1945), the Universal Declaration of Human Rights was adopted as a resolution. This step strengthened the principle that every human being is entitled to inalienable rights and as such spoke to the questions of how states should treat their citizens as well as nationals from other countries (Bloch, 2010; Scheinin, 2016). Article 25 of the United Nations Universal Declaration of Human Rights posits that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UN, 1948).

The experiences of migrant women in accessing health care in South Africa can be situated within the framework of the human security paradigm. The term 'human security' gained momentum in the 1990s at the end of the Cold War between Russia and the United States of America. It was officially coined in the 1994 United Nations Development Report and it proffered the definition which encapsulated the protection of all human beings from both physical and non-physical threats (UNDP, 1994). Emerging work on human security has broadened the definition of human security to encompass "securing people of their physical safety, their economic well-being, respect for their dignity and worth as human beings and the protection of their human rights and fundamental freedom" (Dzimiri and Runhare, 2012: 193). The concept of human security is based on human rights, and one of those rights is any individual's entitlement to proper health care or health security. Scholars like Isike and Owusu-Ampomah (2017: 3179) assert that health security ensures access to health-care systems and quality care; access to safe and affordable family planning; prevention of HIV and AIDS, poor hygiene, teenage pregnancy, substance abuse; and general well-being.

The 1996 South African Constitution was constructed around these principles and asserts that South Africa belongs to all who live in it despite their place of birth or citizenship and all are entitled to be treated with respect and dignity. This makes health a basic human right, as all persons in South Africa have the right to access health-care services (Mafuwa, 2015: 15). In other words, international human rights laws bind states to provide health-care benefits for any individual residing in that state's territory. This means that documented or undocumented migrants in South Africa have the right to proper health-care service on a non-discriminatory basis. There are three 'pieces' of the legislature that guide South Africans on matters relating to migrants and refugees. These comprise the National Health Act of 1998, the Immigration Act of 2002, and the Refugees Act of 1998. According to Alfaro-Velcamp (2017: 60) these laws are inconsistent and they contradict each other.

The National Health Act 61 of 2003, Chapter 1 (2)(c) (RSA, 2003) stipulates that the government will provide health care for the people of South Africa including vulnerable groups such as women, children, the elderly, and people with disabilities. However, the vulnerable do not include migrants and refugees, particularly those who are undocumented who should be considered vulnerable because of their illegal standing (McLaughlin and Alfaro-Velcamp, 2015: 32). The Refugees Act of 1998 (RSA, 1998) appears to be consistent with the National Health Act as it emphasizes that refugees are entitled to basic health services. Chapter 5, section 27 (g) states that, "a refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time" (RSA, 1998: 20). However, the legislation does not refer to asylum seekers or other foreign nationals (Ramjathan-Keogh, 2017: 134). According to Alfaro-Velcamp (2017: 59), the Immigration Act of 2002 contradicts the preceding health laws, as it obliges health care providers to ascertain the legal status of patients before administering care. Section 44 of the Immigration Act states:

> When possible, any organ of state shall endeavour to ascertain the status or citizenship of the persons receiving its services and shall report to the Director-General any illegal foreigner, or any person whose status or citizenship could not be ascertained, provided that such requirement shall not prevent the rendering of services to which illegal foreigners and foreigners are entitled under the Constitution or any law (RSA 2002 – Section 44 substituted by Section 42 of Act 19 of 2004: 51).

South Africa's health system

South Africa's health system is a two-tier health system where patients can either have access to the public or private health-care system, depending on an individual's ability to pay (Mahlati and Dlamini, 2015). Public health care is funded by taxpayers and the private sector provides services to those who can afford medical aid or pay privately for health care. According to government policy documents, approximately 84% of the South African population depends on the government's health sector (Naidoo, 2012). The public health sector is divided into primary, secondary and tertiary health services provided through various health facilities within different provincial departments (Mahlati and Dlamini, 2015: 3). The primary level hospitals include internal medicine, obstetrics and gynecology, pediatrics, general surgery, and general practice. They often offer limited services that require the use of the laboratory and patients do not need referrals to access services. Secondary level hospitals are recognized by their functionality and they usually have five to ten clinical specialties within them. Hence, when someone is referred for secondary care it means that they need a professional who has more specific expertise in whatever problem the patient is experiencing. For instance, a rehabilitation centre is an example of secondary level care. Tertiary level hospitals offer highly specialized equipment and expertise in

areas such as coronary artery bypass surgery, renal or hemodialysis, neurosurgeries, severe burn treatments, and other complex treatments and procedures. Patients are transferred to tertiary level hospitals when primary and secondary level care is not adequate for their condition (Young, 2016: 4). While primary care is free, secondary and tertiary care is subsidized and patients are charged according to a uniform patient fee schedule which determines the amount based on their income bracket and the number of children they have, regardless of their nationality (Expatica, 2020).

In sub-Saharan Africa, South Africa is considered as one of the countries that invests a lot of money in strengthening its public health-care system. However, the results are not equivalent to what is spent (Malakoane et al., 2020). The public health-care system serves a large proportion of the population and this adds pressure as the system battles many challenges. Hospitals are severely under-resourced and doctors and nurses are often demotivated because of the shortage of staff which consequently compromises the quality of patient-care (Maphumulo and Bhengu, 2019: 4). As a result, South African citizens who rely on the public health system experience health vulnerabilities, like prolonged hours waiting in queues, abusive attitudes by staff, and expensive treatment and care. Some hospital and clinic facilities are dilapidated and most people worry that they may contract secondary infections whilst they are seeking care in the public clinics and hospitals (Malakoane et al., 2020). These public hospitals are the same facilities that migrants and refugees use, and their experiences are worsened by several factors.

This paper employs the theoretical lenses of the structural violence theory. According to Samantroy (2010: 6), violence is not always conspicuous; instead, it is invisible and is always ubiquitous in social structures normalized by institutions or regular experiences. The theory is used to show the various forms of invisible violence that make it challenging for Zimbabwean migrant women to access public health-care services in South Africa. Migrant women face several health risks and barriers to accessing public health care which are exacerbated by multiple factors. These include legal restrictions on their status as migrants, poor accommodation facilities, language barriers, and the increasing manifestation of xenophobia which includes prejudice and negative attitudes from health-care workers (Freedman et. al., 2020: 9). Migrant women who are unemployed or working in the informal sector are particularly vulnerable as they encounter economic insecurities that predispose them to high levels of poverty, living in unhealthy environments in the urban areas with poor ventilation and limited sanitation facilities, making them more vulnerable to being infected by communicable diseases (Freedman et al., 2020: 6). In instances when they need to seek health care, they usually cannot afford to pay for treatment. Another factor that makes it challenging for migrant women to access public health care, is legal immigration restrictions. Legal immigration documents play a substantial part in accessing public health care. It is important to note that a significant number of Zimbabwean migrants in South Africa are unskilled and undocumented because of the strict immigration requirements that do not allow unskilled migrants to

apply for temporary work permits (Landau et al., 2005; Mbiyozo, 2018; Hlatshwayo, 2019; Moyo, 2020). Moreover, they are also exposed to other structures of violence like "medical xenophobia" (Crush and Tawodzera, 2014: 659). The term xenophobia is defined as the "deep dislike of non-nationals, whatever their source of nationality" (Landau et al., 2005: 4). Kollapan (1999) argues that the term cannot merely be constructed and defined as attitudes; it must express action or practice. This contention implies that the definition of xenophobia should be constructed beyond dislike and fear; instead, it should include actions of violence that result in bodily harm and damage to property (Harris, 2002: 170).

According to Kange'the and Duma (2013: 160), xenophobic violence occurs in South African communities daily but many incidents go unreported. However, there have been significant nationwide violent attacks on foreigners which took place in April 2008 and October 2015. That violence was sparked by negative comments about foreigners by the Zulu monarch, King Goodwill Zwelithini (Tella, 2016: 2). The city of Johannesburg also recently – during March and October of 2019 – experienced xenophobic riots (Montle and Mogoboya, 2020). The violence is usually characterized by the sporadic looting of property and goods from foreign-owned shops or vending stalls (Cinini and Singh, 2019: 62). Beyond the visible violence carried out against foreigners, xenophobia can also be institutional or structural. It is manifested in South African practices through the exclusion of and discrimination against foreigners in spaces such as the education system, hospitals, banks, police services and the Department of Home Affairs. This concurs with the views of Scheper-Hughes (1995: 143), who contends that structural violence that is experienced every day can be defined as, "little routines and enactments of violence" that are practiced normatively in different administrative and bureaucratic spaces. In the public health care setting, these "little routines" can be considered as the status quo, even though for migrant and refugee patients it is experienced as an assault on their dignity and integrity (see Price, 2012). This implies that xenophobia may be rendered normal, as invisible enactments of violence. As coined by Crush and Tawodzera (2014) these invisible enactments of violence can be termed "medical xenophobia" to encapsulate the argument that some public health-care practitioners discriminate against and express negative attitudes towards foreigners. In the same vein, Adjai and Lazaridis (2013) further strengthen this argument and assert that in institutions, xenophobia can be used to exclude foreigners by practice and not by the design of the policies. Similar to the latter views, Crush and Tawodzera (2014) agree that other practitioners, in the absence of official directives (or not), have the power to withhold services and certainly play a pivotal role in how these services are delivered to foreigners.

However, several studies have provided a counter-narrative to the 'single story' of medical xenophobia and migrants 'perceptions' on accessing health care in South Africa. A recent study by Vearey et al. (2018: 96) reveals that despite the immigration status and the length of stay in South Africa, non-nationals have access to public health-care facilities, particularly clinics. They reported that their choice was mostly

influenced by the fact that most of the "staff was nice", showing that the attitude of health-care providers is an important factor when it comes to migrant women accessing services. Vanyoro (2019: 9) also puts forward the argument that the experiences of non-nationals in the South African public health-care system are complex and equivocal. Vanyoro's study reveals that in Musina, a small border town between Zimbabwe and South Africa, there was no adequate evidence to show that non-nationals were discriminated against or denied treatment because of their nationality, immigration status, and language. Vanyoro (2019) argues that past work on medical xenophobia negates the idea that differences and outsiders are subjectively and socially constructed and negotiated. This is critical to how xenophobic discrimination is experienced (or not) by locals, migrants and refugees across different spaces. This, therefore, shows that in order to access health care for migrant women in South Africa, it is complex and equivocal and there is a wide range of possible experiences.

METHODOLOGY

The findings of this paper are based on a qualitative study with Zimbabwean migrant women in Durban, South Africa. Twenty-two Zimbabwean female migrants were interviewed. An overview of the demography of the women who were part of the study is provided in Table 1.

Table 1: Demography of female participants

Participant	Age	Migration to SA	Occupation	Marital Status
1	39	2008	Tailor	Married
2	32	2012	Hairdresser	Married
3	30	2012	Hairdresser	Divorced
4	37	2008	Hairdresser	Married
5	30	2010	Hairdresser	Married
6	36	2007	Hairdresser	Married
7	49	2009	Maid/Hairdresser	Widow
8	29	2008	Manicurist	Married
9	28	2013	Hairdresser	Single
10	26	2011	Hairdresser	Married
11	30	2013	Street vendor	Single
12	37	1999	Home-based crèche	Married
13	35	2009	Tailor	Divorced
14	41	2007	Street vendor	Divorced
15	40	2010	Home-based crèche	Married

16	30	2011	Street vendor	Divorced
17	27	2008	Street vendor	Divorced
18	33	2010	Street vendor	Single
19	35	2009	Street vendor	Married
20	45	2007	Internet café	Widow
21	25	2016	Maid	Married
22	29	2010	Maid	Single

Participants were aged between 25 and 49 years and self-employed in the informal sector as hairdressers, street vendors, and informal tailors; home-based crèche owners; and internet café attendants. Snowball and purposive sampling techniques were used to recruit the participants. The study did not use the help of a specific organization with the recruitment of participants, hence a key informant who was a Zimbabwean woman was recruited to help identify possible participants in her community. Semi-structured interviews were conducted in Shona since all the interviewed women were Shona-speaking and the interviews were approximately 30–45 minutes long, depending on how the conversations unfolded. With the permission of the participants, the interviews were recorded using a tape recorder. Participant observation was also used as a data collection method. Interactions that were less formal such as 'hanging out' at hair salons and sometimes at the informal stalls set up in the streets, turned out to be a rewarding way of collecting relevant data.

Data gathered through participant observation was recorded by note-taking of all the distinctive behaviors and attitudes from the participants' everyday lives. The interviews were translated and transcribed into English, and thematic analysis was conducted. This involved coding all the data before identifying and reviewing key themes. Each theme was examined to gain an understanding of participants' perceptions and motivations. To ensure that the research was ethical, potential participants were informed beforehand of the nature and the purpose of the research, and why they were being interviewed. They were informed that they could stop the interview when they felt uncomfortable, and they would not be forced to say anything they did not agree to say. Participants were assured of their confidentiality and their real names were not used in the study. Ethical approval was obtained from the University of KwaZulu-Natal Human and Social Sciences Research Ethics Committee (HSS/2112/016 D).

FINDINGS

The findings of the study showed that there were interconnected challenges to accessing health-care services by Zimbabwean migrant women. These included the need for legal immigration documents, xenophobia and discrimination, as well as

language and cultural barriers.

The need for legal immigration documents

The participants revealed that as foreigners they needed to have legal immigration documents to access health-care services. They indicated that when they visited a hospital, they were expected to have valid passports and temporary or permanent permits. Hospital administrators often required their identification documents for verifying their legal status and their eligibility for treatment. One of the participants revealed that it was onerous to try and get treatment without producing documents such as passports and proof of address:

> For a person like me who does not even have a permit or even a passport, it is very difficult to go to the clinic because they always need those things and your proof of where you are staying [Participant 10].

For undocumented migrants, it is impossible to open up bank accounts or be engaged in any activities that require paperwork. That means that they will likely not have any definitive proof of residence required at the public clinics and hospitals (Crush and Tawodzera, 2014: 660) One of the participants recounted the story of another Zimbabwean woman she met at a local ante-natal clinic. She mentioned that the woman was coming to the clinic for the first time to register for her ante-natal appointments. However, the clinic clerk refused to assist her because she did not have a valid or legal permit. Although the woman tried to give the clerk her husband's asylum permit, the clerk said, "We do not want your husband's permit, we want yours". The need for legal immigration forms of identification by health professionals affected the women's access to essential health care. The systematic need for documentation from migrant women in the clinics restricted them from accessing public health care and it influenced some of the women to avoid going to the clinic. Some of the participants noted that it was challenging to get treatment at public clinics and hospitals if they did not present documents showing that they were residing in South Africa legally. Hence, some of the participants opted to use private health-care services, as they were more concerned about the patient's ability to pay, rather than legal immigration documents. Two of the women said:

> Because of the stories I have heard of bad treatment in the hospitals, I normally try not to go there; I would rather go to the pharmacy and get some pills. If it is that serious, I am left with no option but to go to private doctors who are very expensive. But they are better because they do not ask a lot of questions about your passport and permit [Participant 1].

> When you don't have a permit, you are always worried about being caught by the police. And sometimes going to places where they need your passport and

> permit, it's like exposing yourself and you already know that you will not get any assistance [Participant 9].

Some of the participants viewed public hospitals and clinics as 'places of fear'. It is important to note that this study revealed what the participants perceived their access to health-care services to be based on their own experiences and in some instances on what they heard other people in their migrant community sharing regarding their own experiences accessing care at public hospitals. Based on some of these shared negative perceptions, some of the participants said that they feared being denied treatment or their lack of legal immigration documents possibly attracting attention from Home Affairs officials and in turn being detained. This left them with no option but to seek private health care or opting to use self-medication or over-the-counter medication.

While most of the participants were self-employed, they worked in the informal sector, living 'from hand to mouth' and were in no position to afford medical aid and the exorbitant fees required at private health facilities. To avoid these high fees and being asked for legal documentation at public health-care facilities, several of the participants shared that they used over-the-counter medicine. Two of the women said:

> When I am sick, I usually go and buy medication at the pharmacy [Participant 9].

> I have heard so many stories about hospitals in South Africa, such that I go to the pharmacy. I am lucky that I have never been seriously ill ever since I came to South Africa [Participant 2].

However, this increased their health risks as it involved self-diagnosis, even in instances where some of the conditions possibly required treatment by a medical practitioner. These findings resonate with Crush and Tawodzera (2014: 661), who articulate that it is potentially dangerous for anyone, but in particular for undocumented migrants, to continuously use over-the-counter medicine without seeking professional treatment at a hospital, as they could be exposed to inappropriate medicine.

Communication

Several of the participants indicated that when they visited a clinic, some of the nurses communicated with them in the local Isizulu language. The women recounted that they were expected to know and understand the language. However, the reality was that they could only understand the basic elements of the language, like greetings. Beyond that, they were only able to communicate in English. However, communicating in English and being unable to fully express themselves in a local language, was a visible and audible marker of difference that led to some of the participants

experiencing discrimination and xenophobic attitudes from some of the health-care workers. Some of the participants said:

> When I gave birth, the nurse said something that I did not understand. I responded in English and the nurse said she was irritated by people who speak English. She then left the room and I was later assisted by another nurse who was in the same ward [Participant 10].

> I still remember at the hospital, I saw the experience of another woman; she was not from Zimbabwe, but she was from Mozambique. It was not quite pleasing, the way they were talking to her and the way they were handling her. I felt like language was a huge barrier and she could not communicate well [Participant 3].

The participants revealed that not being able to communicate in the local language, heightened their vulnerability as some of the health-care providers used that to scold the women and to show them that they did not belong. In instances where one cannot speak the local language fluently, the only solution would be for the patient and the health-care provider to communicate in the language used most frequently in business and commerce in South Africa, which is English. However, the use of English by the Zimbabwean migrant women often led to hostility and accelerated the nurses' negative attitudes towards them. The language barrier resulted in poor communication and in most cases, it created fear and anxiety in the women when they visited public health-care institutions.

Some of the participants also indicated that their identity as migrants who spoke a different language subjected them to poor treatment even though they had legal status. They felt that they were not cared for as people who needed health care. Instead, their identity as being foreign, subjected them to poor treatment and judgment from some of the health professionals. The participants regarded those actions as xenophobic as they experienced discrimination from some health-care providers who blatantly pointed out that they were not happy with migrants and refugees using the same health-care system as South Africans. Some of the interviewed participants revealed that the resentment that some health care professionals displayed towards them was deeply entrenched in hatred and disdain for foreigners. This was revealed in what some of them said:

> I gave birth in 2016, and there was an older midwife who told me that I should stop giving birth because the population in South Africa is increasing and they did not need more foreigners. She told me that I was supposed to find other means of not giving birth as this was not my country (Participant 9).

> Especially at the hospital, if they see that you are a "kwere kwere" they will not

> treat you well. I know of my neighbor who suffered terribly during birth in hospital and the nurses would come and say, "is it you removed Mugabe, why is it you are still here in South Africa?" (Participant 12).

Some of the participants also said that they had been denied treatment in hospitals and they were told to go to other facilities:

> Sometimes you go to the hospital and you expect that they will at least check you and tell you what's wrong. But you know they can give you excuses and tell you that you were not supposed to come to the hospital and you should go to the clinic. Is it I am here now and I need assistance? Why can't they just assist me? What if it's a serious problem and they are busy telling me to go from one place to another? [Participant 18].

One of the primary challenges in assessing the reasons why the participants faced difficulties when they tried to access public health care is the assumption (often held by the Zimbabwean migrant women themselves) that when they received poor medical treatment from health-care workers, it was driven by the health-care workers' xenophobic attitudes. However, a study conducted by Shaeffer (2009) argues that it is imperative to acknowledge that not all instances of poor treatment can be labeled 'medical xenophobia'. Instead, the language barrier and the lack of understanding of South Africa's health-care system often ended in many migrants and refugees seeking care at the wrong facilities. According to Mojaki et al. (2011) the South African health-care system follows a hierarchical referral system where health care providers at the lower level of the health system seek the assistance of providers who have more resources and capacity. Based on the latter narrative, it is possible that when some of the participants were referred to other facilities, they possibly misconstrued it as denial and 'medical xenophobia'. Based on the definition of xenophobia (see Landau et al., 2005), for it to be considered 'medical xenophobia', medical treatment has to be wrongfully denied to migrants and refugees on the grounds of their nationality or their legal right to live in South Africa. However, other reasons might lead to medical care being wrongly denied. South Africa's health-care system is regarded as being in a state of disrepair and experiencing various challenges (see Maphumulo and Bhengu, 2019). Among the various challenges is the shortage of staff, which implies that public health-care workers often work long-hour shifts and they are likely to be exhausted. In some instances, the exhaustion and fatigue they experience possibly influence their negative attitudes and behavior towards local and foreign patients (Crush and Tawodzera, 2014: 666).

Challenges in accessing sexual and reproductive health care

Several of the participants also indicated that they had challenges accessing sexual and reproductive health-care services. They revealed that they did not feel secure about

the way they accessed contraceptives from public-health institutions, particularly after giving birth. This was recounted by one of the women:

> I told the midwife that I was comfortable using birth control pills but, just after giving birth, I remember I was injected twice and thought these were anesthetic injections. Two months after giving birth, I was still experiencing problems with bleeding. When I went to the local clinic, that was when I was told that this was normal as I had been given the injection for birth control [Participant 20].

In most cases, as the participants revealed, the women unknowingly started using two birth control methods at the same time, which usually had negative effects. The above narrative shows how some of the participants were unaware of the type of contraceptives they were taking. This resonates with the findings of Munyaneza and Mhlongo (2019: 11) that migrant and refugee women are often not asked for their consent when they are administered contraceptives by injection. It is important to note that failure to obtain informed consent from patients before administering contraceptives is not something that only happens to migrant women. According to Lince-Deroche et al. (2016: 101) local South African women usually use or continue using contraceptives they did not consent to after intentional or unintentional rushed and substandard counseling with nurses. However, the findings of this study revealed that there are some instances unique to migrant women that adequately capture the existence of 'medical xenophobia'. One of the participants said:

> The nurses came, and they did not even ask me, they just told me to roll up my nightdress sleeve and I assumed they wanted to put me on the drip. When I saw her take out the implant package, I immediately told her that I didn't want an implant. But she just continued, and she told me that the implant was for five years and it was going to keep me from giving birth in a country that was not mine. I later went to see a private doctor after a month for it to be removed as it had a lot of side effects (Participant 4).

It is important to note that women's bodies are at the center of sexual and reproductive health rights, yet, in most instances, they do not have power over the decisions made about their bodies and sexuality. Significantly, for migrant women, this study revealed that violations of their sexual and reproductive health rights were often worsened by different structures of insecurities like xenophobic attitudes. From the latter narrative, the nurse mentioned that using a contraceptive that lasted for 5 years would prevent the participant from giving birth in a foreign land, and this is indicative of some of the xenophobic undertones that migrant women encounter when they access public health-care facilities. The ill-treatment that the participants received, constructed their identity as second-class citizens who do not quite belong or fit into South

African society. The attitudes and sentiments from health-care professionals cause the women to feel unwanted in a foreign land where they hoped to find security and better livelihoods. Despite the negative experiences from some of the participants, it is also important to note that two of the women had positive experiences and they felt that they were treated well when they accessed public health-care facilities. The women recounted:

> When I gave birth to Sunshine at Addington Hospital, I do not want to lie, I received the best treatment [Participant 8].

> The health system here in South Africa is much better than the one that we have back home, where there are no doctors and the nurses are always on strike. If you send someone to the hospital, it's like you are giving up on them and sending them off to die. Here, it is better. I have never faced any challenges when I usually go to collect my pills for blood pressure and diabetes [Participant 22].

DISCUSSION

It is clear from the narratives that several factors exacerbate the health risks of Zimbabwean migrant women. South Africa is an inherently violent country and migrants are particular targets of violence and they are often exposed to xenophobic violence (Crush et al., 2017; Munyaneza and Mhlongo, 2019). It is also a society that suffers from high levels of rape and sexual gender-based violence and migrant women are not an exception. They live precariously and their lives are at constant risk, both during their journey to this country, and during their residence in South Africa (Von Kitzing, 2017; Hlatshwayo, 2019).

Even though undocumented migrant and refugee women are entitled to their universal human health rights, the inconsistencies in the policies and legislature regarding the health care of migrants and refugees, subject them to various health risks and vulnerabilities that make it difficult to access public health care. The legal authority has been misplaced onto hospital administrators who do not have the authority to decide people's legal immigration standing (Alfaro-Velcamp, 2019: 64). The most serious barriers and obstacles to their health, regardless of the Zimbabwean migrant women being documented or undocumented, are their experiences of discrimination and negative attitudes on the part of individual care providers. Shaeffer (2009: 8) observes that, "the health rights that are afforded to migrants on paper are belied by the harassment and denial they face in clinics and hospitals".

The lack of documentation or identifying as foreign, exposed the women to health risks. More than anything, the narratives show the power dynamics between health-care providers and migrant women. In as much as health-care providers are constitutionally obliged to serve every patient with dignity and respect regardless of their nationality, they have a powerful position in the execution of their duties. In

some instances, that power was abused, making it difficult for the migrant women to access proper health-care services. The women revealed that they experienced fears of being reprimanded, being shouted at and their concerns being ignored.

It is important to note that the language barrier between the migrant women and some of the health-care providers influenced the negative and discriminatory attitudes. The inability to fully express themselves in English or the local language, coupled with negative discriminatory attitudes towards foreigners by locals, made it challenging for the migrant women to access quality health-care services in South Africa.

The belief that the presence of foreigners in South Africa means that the country's population will grow, is deeply rooted in discriminatory and xenophobic sentiments. The widespread negative beliefs and knowledge about migrants amongst local South Africans influence individual health-care providers' perceptions that if foreign women gave birth in South Africa, they would be straining the country's resources and worsening South Africa's structural, social and economic problems (Crush and Tawodzera, 2014: 663).

More often, the health rights of migrant women are overlooked and infringed because of the strong negative beliefs towards foreigners. As cited in Crush et al. (2013), Benatar (2004: 81) asserted that most South Africans are not content with the quality of the health-care system in public institutions. This is attributed to staff shortages and increased workloads. However, some of the South Africans, including the health-care providers, are of the view that the poor service delivery is caused by an influx of foreigners, who they perceive as bringing infectious diseases and socio-economic problems to the South African health-care system. Walls et al. (2016: 14) articulated that although there is a clear indication of the increased number of people moving into South Africa, the impact of migration on the health-care system is debatable, with the assumptions and beliefs often driving responses instead of data and evidence. The perceptions and views of the health-care providers can be considered as being xenophobic, as they influence their thoughts, responses, and behavior towards migrant women. Writing in the 1990s, a study conducted by Jewkes et al. (1998) provides a counter-narrative to the latter view. It established that both local and migrant patients suffered due to the poor health-care system, which currently continues to deteriorate daily. Scholars like Crush and Tawodzera (2014: 9) observe that the public health-care system in South Africa is heavily overburdened and most public facilities struggle to provide sustainable quality health care. Hence, in some instances, Zimbabwean migrant women might associate any kind of ill-treatment in hospitals with xenophobia.

CONCLUSION

This paper evokes an understanding of the context of the vulnerability of Zimbabwean migrant women when they are accessing the public health-care system in South Africa. Although there are singular events that display the specific poor treatment of

migrant women when accessing public health care, it is important to highlight that some of the incidents might possibly be misconstrued as being unique to migrant women. The findings of this paper highlight that the issues surrounding the access of public health care are constructed on the assumptions and perceptions held by migrant women themselves. Hence, it is possible that any poor treatment experienced accessing health care can easily be associated with 'medical xenophobia'. The term 'medical xenophobia' has been used several times in the literature, referring to the negative attitudes and experiences that migrants encounter when accessing health care (Crush and Tawodzera, 2014; Zihindula et al., 2015; Munyaneza and Mhlongo, 2019).

It is imperative to note that emerging research should not only focus on the single story of migrant women being treated badly in hospitals, but it should also consider the existence of other invisible structures of violence like language barriers and the women's lack of understanding of the state of the South African public health-care system as reasons for some of the poor treatment they receive. We cannot dismiss the fact that there is a thin line between 'medical xenophobia' and a deteriorating South African public health-care system, which invariably leads to vulnerability when accessing quality care and services, for both local and migrant women.

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