

**Suffering and Surviving Beyond Home Borders:
Experiences of Zimbabwean Migrant Women in Accessing Health
Care Services in Giyani, South Africa**

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DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Date: **August 2017**

Abstract

This dissertation explores documented and undocumented Zimbabwean migrant women's experiences in accessing public health services in South Africa. It unpacks migrant women's vulnerability and subsequent coping strategies they improvise against the shocks and stresses they face. Data in this study was collected over two and a half months using qualitative anthropological techniques. I used key informant interviews, unstructured interviews, life-histories and focus group discussions. The data was analysed using Chabal's (2009) model of 'suffering and surviving'. Findings in this study reveal that Zimbabwean migrant women in South Africa are excluded from accessing public health services, despite them being accommodated in policy frameworks and the South African Constitution. The excluded women improvise various strategies in accessing health services. In coping with exclusion, they use strategies such as marriage, social capital, local institutions and indigenous knowledge. These strategies act as safety nets in times of health shocks and stresses for both women and their unborn and born children. In terms of indigenous knowledge, women depend on traditional medicines from traditional midwives. In some cases they consult spiritual healers as a strategy of anticipating danger and coping with various health ailments. Vulnerable women also utilise their linking capital and receive assistance from local institutions such as NGOs. On the horizontal level, they invest in bonding capital as a coping strategy to deal with health challenges. Furthermore, excluded women's horizontal relationships in civic informal institutions, such as money rotating clubs and burial societies, reduce their vulnerability to exclusion and help them fortify their resilience.

Dedication

I dedicate this dissertation to my late father and my mother whose irreplaceable support, earnest advice, prayers and proper guidance have taken me this far.

Also, I dedicate this work to my brothers and sisters, Tawanda, Takunda, Masimba, Kurai, Rebeka and Etina for their incomparable financial and moral support during my studies.

Likewise, I dedicate this dissertation to Zimbabwe's millions of university graduates who are unemployed and trying hard to make ends meet. Do not lose hope, guys, as in the fullness of time all shall be well.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organisation
DOH	Department of Health
ESAP	Economic structural adjustment programme
FGD	Focus group discussion
HIV	Human Immune Deficiency Virus
IOM	International Organisation for Migration
MNCWH&N	Maternal, Newborn, Child and Women's Health and Nutrition
MSH	Management Sciences for Health
NGO	Non-governmental organisation
PHC	Primary health care
ROSCA	Rotating savings and credit association
SAMP	Southern African Migration Programme
SAP	Structural adjustment programme
SDG	Strategic development goal
StatsSA	Statistics South Africa
TAC	Treatment Action Campaign
USAID	United States Agency for International Development
UN-INSTRAW	United Nations International Research and Training Institute for the Advancement of Women
WHA	World Health Assembly
WHO	World Health Organisation
ZIMSTAT	Zimbabwe National Statistics Agency

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Chapter 1. Introduction and Background

In Search of a Better Living

The woman, a 28-year-old mother of three, and her husband relocated to the rural village of Zaka after failing to cope with urban life in the central Zimbabwean town of Masvingo. Zaka is a district in Masvingo Province, Zimbabwe and is located 86 km southeast from Masvingo in the Ndanga communal land. Masvingo (before 1982 known as Fort Victoria) is a city in south-eastern Zimbabwe and the capital of Masvingo Province. Yet farming as a livelihood strategy was negatively affected by erratic rainfall patterns. Recurrent droughts took their toll on the family. When her husband passed away, the woman relocated to the home of her birth, also in Zaka, in order to cope with life's uncertainties. Finally, increasing livelihood challenges forced her migrate to South Africa, for greener pastures. Her name is Yvonne and this is how her journey to South Africa began.

Having no other means of survival, Yvonne left her children with her natal family. She embarked on a journey to South Africa hoping to find a way to fend for them there. As she had not acquired a work or residence permit, she was given a 30-days entry visa by South African immigration officials at the border. Yet the month provided by the visa was insufficient for her to find a job and send remittances back home.

Yvonne's experiences are common to Zimbabwean migrants in South Africa and other migrants across the world. Mbembe (2017) explains that the right of non-citizens to cross national borders and enter a host country is becoming increasingly procedural and can be suspended or revoked at any time and under any pretext. Despite South Africa's recent history of enabling in-migration, its regimes of control have concurrently become stricter due to an increase of this migration. In the wake of this increase, foreigners have increasingly been blamed for the country's socioeconomic ills, including high crime and unemployment

rates. Much of this animosity has specifically targeted lower-skilled African migrants, seen to be competing with locals for employment and public services. In this context, increasingly restrictive migration and documentation policies play well with the local population.

An enterprising woman, Yvonne learnt strategies that enabled her to avoid having to cross the border monthly in order to renew her status as visitor to South Africa. In conversations with other women at the border gate who were also travelling to South Africa, she learnt that she should first have her passport stamped at the exit as departing the country, only to sneak back in before actually crossing South Africa's borders, thus without any visa. The bustling activity and restlessness at the border post would assist her doing this. Migrants were using different ways and means of entering South Africa: some used work and residence permits, some bribed immigration officers, and others entered unnoticeably, 'cloaked' in the same way as Yvonne.

Once Yvonne's passport was stamped with 'Departure', the South African system recorded that she had returned back to Zimbabwe, while she was in fact in South Africa. In this manner she became an undocumented migrant with a passport but an invalid presence in South Africa according to the 2004 Immigration Act of South Africa. She thus became vulnerable to many risks, with limited assistance or protection from the state.

Despite the fact that she did not have a valid visa, Yvonne managed to negotiate her way inland. She had a friend who stayed in Modjadjiskloof close to Tzaneen in Limpopo Province. She chose to settle there. After finding work and temporary housing, accessing healthcare was one of the problems she faced. Yvonne could not access the hospital because she lacked the appropriate documentation that would grant her access. The security personnel and healthcare practitioners in most of the hospitals she tried to access would not allow her and other 'foreigners' to enter. They first required the migrants to produce documentation that confirmed their right to be in South Africa. The migrants were confronted with various kinds of hostile attitudes and

stereotypes at these public hospitals.

Yvonne accepted that the lack of documentation is a burden to every migrant. She described this lack as leading to the exclusion of many migrants from healthcare. She acknowledged that migrants might have rights but that these were often violated by South African individuals and institutions. She explained her experiences in this way:

I could not access government hospitals and clinics. I had to buy medication from pharmacies. They are also limited in that they would not provide other treatments without doctor's prescription. For some ailments I had to make out with traditional healers or medication than risk being verbally abused or turned away in government hospitals.

Despite being discriminated against in South Africa, the hardships at home in Zimbabwe strengthened her resilience. No matter how sick she could be, she would go to work first and seek medication later. She said that, like most of the migrant women with whom she interacted, she had to put her job first at the expense of her health.

Against all odds, Yvonne toiled and eventually obtained a permanent residence permit. She now owns a house in Giyani Section F and is happily remarried. She is sending remittances back home to her children and they are living a better life.

Yvonne's story is similar to that of many Zimbabwean migrant women. My study examines migrant women's experiences and vulnerability to shocks and stresses. It also examines various adaptive and innovative strategies and improvisations to circumvent the exclusion from the South African health system. I discuss how an increasing number of women is migrating in order to escape terrible economic and political situations in their home countries. Yet regardless of this increase, migration policies have continued to exclude women and leave them with few livelihood opportunities (Geddie, Oikonomou and LeVoy 2007; Lefko-Everett 2007).

Migration in Pre-colonial and Colonial Zimbabwe

Migration from Zimbabwe is not a new phenomenon. It can be traced from the pre-

colonial period to the period of European conquest and the defining of colonial boundaries and borders, and stretches into the post-colonial period. People moved from one area to another as the need arose (Mlambo 2000). Prior to colonialism, boundaries between polities were amorphous. This allowed the individuals, families and ethnic groups to move with relative ease. Yet, migration did not end with the advent of colonial boundaries; rather it accelerated as a result of various coercive measures and incentives that were introduced to secure the growing demands for labour on South African mines and ‘plantations’.¹ Many people, especially men, went to look for work in the farms and mines within and beyond the boundaries of the new colonial structures. During the colonial period, Zimbabwe, then called Rhodesia, was both a sender and receiver of labour migrants (van Onselen 1976; Johnstone 1976). Sometimes Zimbabwe would be used as a conduit through which labourers were supplied from Malawi and Zambia to South Africa (Mlambo 2000). Most Zimbabwean migrants headed to South Africa, informally referred to in Shona as *Wenera* or *Joza* (Mlambo 2000; van Onselen 1976), and left their families behind. Migration to South Africa was male dominated, with men engaged in a circular labour migration pattern to mines and farms and home after months or years of work (van Onselen 1976). Zimbabwe, in turn, was also host to labour migrants from Malawi, Zambia and Mozambique, many of whom settled permanently in Zimbabwe. Labour migration connected many countries in Southern Africa into one big source of labour power (van Onselen 1976; Mlambo 2000).

Migration in Post-Colonial Zimbabwe

In the post-colonial era, migration trends have changed (Potts 2010). While men continue to migrate locally, regionally and internationally, the number of female migrants has increased significantly. Outward movement from Zimbabwe has been facilitated by various factors such as the application of an economic structural

¹ While labourers on South African farms may not have been enslaved as those on American and Caribbean plantations, the form of their exploitation and their lack of control over the conditions of their own lives was of a very similar nature. By using the term ‘plantation’ here, I suggest that it may be useful to think of South African labour conditions in parallel to American and Caribbean plantations.

adjustment programme (ESAP), introduced in the early 1990s, and a volatile land reform programme implemented from the early 2000s. The ESAP was introduced as panacea for the deteriorating economy of Zimbabwe, but did not succeed and led to an exodus of women to South Africa (Potts 2010). Structural adjustment programmes (SAPs) were introduced in many developing countries in the late 20th century when they were desperately in need of help from developed countries (Pophiwa 2009). Mlambo (2000) notes that, subsequent to the ESAP's failure, many Zimbabweans noted an escalation of rates and taxes. Their need to augment their income intensified. Other reasons significant to the out-migration of Zimbabwean women included the desire to acquire household goods and consumer products which they could sell at home in order to secure sustainable incomes. The dire economic situation at the time was exacerbated by a prolonged drought in Zimbabwe (Mlambo 2000). This hit women in particular since it was them who stayed in rural areas heading their families, whilst their spouses were working in towns and mines (Potts 2010). The dawn of the new millennium in Zimbabwe saw a massive economic meltdown and increasing political chaos (Hartnack 2005; Morreira 2010). As a result, many women embarked on circular migration for purposes of trading or job hunting in South Africa. As we have seen in the opening story of the thesis, they used different ways and means of entering South Africa (Pophiwa 2009).

Gendered Migration in Post-colonial Zimbabwe

People are entitled to cross international borders as they wish, and there are no charges for crossing from Zimbabwe into its neighbouring states; but it is also the case that women in particular pay very dearly for such crossings, especially where these are illegal. Many women experience sexual violation as part of the cost of crossing. In many situations, women are more vulnerable than men, especially in regional countries such as South Africa (IOM 2014). Thus the International Organisation for Migration (IOM) notes that along their way to South Africa migrant women, especially those who use irregular ports of entry, are gang-raped, abused or killed. Upon arrival in South Africa, abuse and gender-based violence at workplaces and exclusion from state healthcare services are challenges they encounter differently than their male counterparts. However, driven by the desire for economic opportunities, Zimbabwean migrant women remain resilient and keep going despite

the obstacles they face (Pophiwa 2009). This contributed to a growing feminisation of migration, with thousands of Zimbabwean women travelling to South Africa in the first decades of the 21st millennium (Morreira 2010).

The pattern is not particular to Southern Africa. Migration in Africa has become irregular and feminised as women are now migrating on their own, sometimes with their children (ZIMSTAT 2012). According to the Zimbabwe National Statistics Agency (ZIMSTAT 2012), women are increasingly migrating as the main economic providers for their households. This has made a significant contribution to their visibility within migratory flows. The United Nations International Research and Training Institute for the Advancement of Women (UN-INSTRAW, cited in Pophiwa 2009) provides the following figures: women currently constitute 49.6% of global migratory flows, though the proportion varies significantly by country and can be as high as 70% to 80%. More than five per cent of the South African population comprises cross-border migrants, with Zimbabweans contributing approximately three million to this figure (Crush and Tawodzera 2016). Most Zimbabwean migrants who go to South Africa settle in Limpopo Province first because of its proximity to home and the existing density of local Zimbabwean networks, before proceeding to main cities such as Johannesburg and Pretoria (Ramathetje and Mtapuri 2014).

Migration and Gendered Vulnerability

Zimbabwean migrant women experience hardships such as xenophobic attacks and exclusion from employment (Muzondidya 2010). Their exclusion from state healthcare services is common despite South Africa's protective health policies. Geddie, Oikonomou and LeVoy (2007) note that despite migrants' health rights being enshrined and recognised in the international human rights treaties, they are neglected and abused in South Africa. Nyamnjoh (2006) states that, despite the country extending legal rights to non-citizens, migrants are not always able to claim these rights since their social membership is limited or non-existent at all. Migrants to South Africa are vulnerable to the rising assertion of anti-immigration right-wing politics and severe state policies towards them (Morreira 2010). Their vulnerability to these forms of violence and control is also increased by the lack of documentation. This, in turn, feeds into other, subtler challenges like bad staff attitudes in state

institutions, risks to safety and security, and vulnerability (Makandwa and Vearey 2017).

Geddie, Oikonomou and LeVoy (2007) contend that it is common that migrant women are denied access to healthcare services, face exploitation at work places and, at times, are susceptible to gender-based discrimination and violence. Migration and mobility can place migrant women in precarious positions; even the unbearable conditions created by the journey itself can give rise to risky behaviours and stress responses that compromise the health of these migrants (McGregor and Primorac 2010). Lefko-Everett (2007) asserts that, because migrant women are marginalised, they are more likely to engage in sexual activities as an adaptive and resilient measure to cope with the precarious conditions that define their existence in foreign countries. This also increases their chance of contracting HIV, thus heightening their vulnerability.

Adaptive Options for Vulnerable Categories

When migrant women—rational and innovative beings—face exclusion, xenophobia and resentment, they use different strategies to manage potential health threats. Zimbabwean migrant women with whom I worked in the Limpopo region of Giyani also face challenges similar to those described above. These challenges threaten the reproductive health of these women as they cannot access continuous contraception, adequate antenatal care, medical assistance to ensure safe deliveries and related medical care. And yet it is crucial to highlight how Zimbabwean women exhibit resilience to off-set the dangers to their health and lives. As this study shows, the women embrace local institutions, traditional medicine and religious approaches to ill health as coping mechanisms, and draw on regional networks of non-governmental organisations (NGOs), such as the Treatment Action Campaign (TAC) against HIV and AIDS. NGOs, community-based organisations (CBOs), and community structures play a crucial role in building the adaptive capacity of vulnerable migrant women, either by providing them with biomedical services or helping them to settle in the country.

This study finds that migrant status or insider status in Limpopo are heavily influenced by documentation and sets of relationships. Establishing robust relationships makes migrants belong to the community they live in and facilitates

access to healthcare services and to livelihoods. Migrants make use of social networks² and marriages in order to access healthcare services and as adaptive options to reduce their vulnerability to potential disasters. My research demonstrates that social relationships (both formal, such as savings groups and churches, and informal, such as friendships), marriages, social networks, and the cultivation of conviviality play a pivotal role in legitimising and regularising migrants' lives in Giyani. Using a wide range of social networks, migrants at individual and group level invest in collective action as a social safety net which reduces their vulnerability (Putnam 2000). Depending on social networks helps many migrants cope with the effects of exclusion from state healthcare services. This study also unveils the creative schemes that migrants employ to cushion and subvert the effects of their institutionalised exclusion from healthcare services.

Conceptual Framework: Suffering and Surviving

This study adopts Chabal's (2009) model of 'suffering' and 'surviving'. These concepts are used to break the nexus between women's vulnerability and their coping strategies to deal with their lack of access to public health services in Giyani, South Africa. I embrace these concepts because they are well adapted to the African context with which this research is situated. Chabal's model helps to capture the cycle of life of an individual migrant and of a social group, from birth to death, and allows me to accentuate these areas. It is a contextually drawn framework for the study of some of the most relevant questions about the lived experiences of a people in a 'foreign' land. The framework helps reveal migrant women's vulnerability and the coping strategies they creatively develop to overcome the adversities, stresses and shocks they are faced with.

As Chabal (2009: 152) explains, 'suffering' can be equated to difficulties such as illness, lack of documentation, exclusion from healthcare services, resentment and conflict that migrant women face in their daily lives. Suffering covers the full range of difficulties that migrant women confront from the initial

² Social networks are social structures made up of a set of social actors (such as individuals or organisations), sets of dyadic ties, and other social interactions between actors.

phase of the migration process until settlement. Mbembe (2017) notes that suffering can also be explained as violence that is backed by new logics of incarceration, expulsion and deportation at national boundaries. In South Africa it is very common for people to respond to the question ‘How are you?’ with ‘We are suffering.’ Just as many poor South Africans will give this response, Zimbabweans will answer ‘Zvakapressa’ (life is hard pressing) or ‘Zvakadzvanya’ (things are tough).

Despite South Africa’s inclusive progressive healthcare policies and immigrant rights regime, in practice migrant women’s lack of proper documentation precludes them from accessing state provided reproductive healthcare. The right to healthcare in South Africa is stated in three sections of the constitution, which provide for access to reproductive healthcare, emergency services, basic healthcare for children and medical services for prisoners or detained individuals or groups. Section 27(3) of the constitution states that no one should be denied emergency medical treatment, meaning it is everyone’s right to access healthcare. Section 28(1)(C), in turn, provides basic healthcare services for all children under six (Makandwa and Vearey 2017). The obligation of Section 27 is to respect the rights of migrant women and their children and to assist the state to ensure that no healthcare practitioner will deny anyone access to healthcare (Makandwa and Vearey 2017). All these proposed actions must include and meet the needs of vulnerable groups, including migrant women and their children (Crush, Chikanda and Skinner 2015). The gradual burdening of the public provision of healthcare, on which many ordinary migrant women depend, has affected those migrant women who have no social networks or capital to buy private health services (Pophiwa 2009; Chabal 2009). Migrant women thus suffer because of negligence of the state: the South African government has failed to implement concrete health policies on the ground that would bring benefits to migrant women.

Chabal also explains ‘suffering’ in terms of the three axioms of violence, conflict and illness. *Violence* is not only physical in nature. As I show in this study, it is expressed in the institutionalised and fatal neglect by the state of implementing what is clear ‘on paper’ (health policies) on the ground, so that the latter becomes considerably more opaque when experienced by those who do not ‘have papers’ (documentation). Violence includes, but is not limited to, administrative strategies and practices that withhold from or deny to foreign migrants documentation, and

hence legal rights. The South African Department of Home Affairs has displayed increasingly shifting practices that reveal an official ambivalence toward granting foreign migrants documents and the rights that accompany them. On the same level, healthcare practitioners withhold from or deny to foreign migrants healthcare, and hence legal rights, even when these are provided for in the constitution. Chabal describes such institutionalised violence by the state as a calculated violence of neglect. *Conflict* alludes to medical xenophobia that Crush and Tawodzera (2014) describe in terms of the negative attitudes and practices of health professionals towards migrants and refugees, based purely on their identity as non-South Africans. *Illness* speaks to the ill-health, health risks, and shocks and stresses migrants women confront.

Chabal uses his second term, the concept of ‘surviving’, to explain the lived experiences of Africans and the survival strategies they deploy to overcome threats to health and life. He defines surviving in terms of the three axioms of migration, informalisation and networking. In my thesis, I equate surviving to coping strategies used by Zimbabwean women when faced with disasters. Chabal (2009: 21) explains surviving as ‘the specific efforts, both behavioural and psychological, that people employ to master, tolerate or reduce stressful events’. Migrant women also survive by circumventing boundaries that are both obstacles and opportunities for those who are trying to make a living through migration or trade. Chabal argues that in this way Africans—and, as I show, Zimbabwean migrant women—exercise agency to circumnavigate the boundaries of the national state. These are the adaptive and resilient strategies Zimbabwean migrant women deploy to negotiate *migration* processes and their associated risks, shocks and stresses.

I draw attention to the micro-picture of what migrant women do daily to sustain, and if possible better, themselves and their families in Giyani. Zimbabwean migrant women survive through informal networks. They get access to healthcare through various religious realms, social networks, marriage, and various other platforms. I show how they draw on activities that are not entirely economic but made up of socio-cultural aspects that are vital to understand migrants’ everyday lives and health-seeking practices in Giyani. This includes *informalisation*, the process whereby the modern and the traditional interact in a dynamic of agency that seeks to overcome existing constraints to living a decent life (Chabal 2009). Migrant

women use all the accessible social *networks* as a means to survival and good (social) health. Here, agency is applied to the opportunities that arise from the combination of traditional and modern modes of healthcare to subvert the effects of institutionalised exclusion from public healthcare. In relation to Chabal's notion of 'surviving', I show how social networks are knitted together by similar social and demographic traits and collective activities. The thesis demonstrates the ways that suffering and surviving materialise in the everyday health-seeking behaviours of migrants.

Relevance of the Study

Research on migration and health in sub-Saharan Africa has largely focused on diseases experienced by migrant women. These commonly include but are not limited to tuberculosis, HIV/AIDS and pneumoconiosis (see Kahn et al. 2003). Bamford (2013: 49) notes that

the past few years have been characterised by a number of international and national commitments and interventions that focus on improving maternal, newborn and child health. ... In SA, ... the first national Maternal, Newborn, Child and Women's Health and Nutrition (MNCWH&N) Strategic Plan provides a road-map for achieving improved survival and health for women and children.

She argues that the 'restructuring of primary healthcare (PHC) also provides an opportunity to improve coverage and quality of maternal and child health services' (Bamford 2013: 49). He suggest this can be done through reaching learners in schools, connecting with households through visits by community health workers and improving clinical governance at local level.

Most research produced by NGOs, such as the TAC and the IOM, academics and governments tend to view migrants as passive beings. The TAC and IOM both work to promote humane and orderly migration for the benefit of all regardless of citizenship, colour, creed, race or origin. Most of these organisations, researchers and governments agencies are not staffed by migrants, much less by migrant women. Their research focuses on defending the rights of 'vulnerable categories' but hardly ever gives the embattled migrant women room to tell their stories in their own

voices. Rather, the researchers treat migrant women as passive victims who are not versatile enough to craft social networks and other strategies to deal with the challenges they confront. Their approach thus tends to ignore fundamental aspects such as social relations, social networks and individual dispositions that influence migrants' health seeking behaviour (Geddie, Oikonomou and LeVoy 2007). There are a number of issues that need to be noted in this literature: it focuses on migrants as passive victims with few creative strategies to survive and to interact with one another. The focus of these studies was rarely on interfacing social engagements within and between migrant groups, and the effects or lack thereof on social integration. There were fewer attempts to focus on the influence of migrant social engagement and survival in a context where migrants are perceived to be intruders rather than an opportunity. My focus on these issues adds a new dimension to the understanding of both theoretical and practical perspectives of the unique levels of lack of access to healthcare and the ability to secure well-being that migrants' experience.

Using an anthropological lens, the present research addresses various strategies deployed by Zimbabwean migrant women and those around them in order to deal with exclusion from healthcare. The research extends its scope to investigate how migrant women are responsible for their own and their families' health, especially that of their children. It is thus significant in addressing pertinent questions of how migrant women access productive and reproductive healthcare against a backdrop of institutionalised exclusion and one in which they are pinpointed as being the cause for the creation and widening of social fissures.

Objectives of the Study

The aim of this research is to examine the experiences of Zimbabwean migrant women in accessing health services. It does so by considering the context of risks, shocks and stresses that Zimbabwean migrant women encounter and the subsequent strategies the women develop in order to negotiate, cushion and subvert them. The first objective focuses on the lived experiences of Zimbabwean migrant women and their access to public health facilities before, during and after giving birth, seen against the backdrop of documentation such as work and residence permits. The second objective is to examine the nature and significance of various adaptive and

resilient strategies Zimbabwean migrant women improvise to cope with their exclusion from state healthcare systems in Giyani. The third analyses the migrant women's simultaneous use of traditional modes of healthcare, biomedicine and spiritual healing offered by churches as strategies to cope with health threats. Last, the fourth objective interrogates the role of local institutions in adapting to new health challenges.

Study Area: Giyani of Mopani District, Limpopo Province

Giyani is situated in the north-eastern part of Limpopo Province of South Africa (see Figure 1.1). It was the capital of the former Gazankulu Bantustan. It is located where the R578 from Louis Trichardt meets the R81 that runs from Polokwane to the Punda Maria gate at the Kruger National Park and is 470 km away from Johannesburg, South Africa's economic hub, and 104 km from Tzaneen, the closest large town. It is situated at the heart of the Limpopo bushveld on the northern bank of the Letaba River, west of the Kruger National Park. It was founded in the 1960s, during the time when the apartheid government imposed separate development in the country, and was intended as administrative centre for the Tsonga people. It is now the administrative capital of Mopani District Municipality. The province has a population of 5.6 million, with Giyani Municipality holding 244 217 people in a total of 63 537 households. The municipality is divided into 30 wards that are grouped into 5 clusters. Most wards have a population exceeding 5000 people (Limpopo DOH 2016). Since the new dispensation in South Africa in 1994, Limpopo Province has become a centre of confluence where many nationalities meet. The province is affected by migration as it lies at the border of Zimbabwe, Botswana and Mozambique (TAC 2014). I focused my research on Giyani because it is densely populated with Zimbabweans: being close to their homeland, they experience lower expenses when travelling inland or returning home from here. Giyani is also convenient for undocumented migrants who travel from the border on foot until they reach a safe distance inland. The Giyani area is still developing: it has one major hospital, the Nkhensani Hospital, and several smaller healthcare facilities like the Giyani Health Centre, the Krematert Clinic and the Dzumeri Clinic, though these are insufficient to cater for the ever increasing host and migrant population in the area.



Figure 1.1: Map of South Africa showing the location of Giyani. Source: Ezilon.com.

Data Gathering and Study Approach

I initially conducted preliminary fieldwork for two weeks in December 2016, during the feasibility period of my research. A feasibility study is a controlled process of identifying problems and opportunities, determining objectives, describing situations and mapping the field of study (Bryman 1998). It assisted me in mapping my field site and identifying potential key informants, interlocutors and participants. I used the preliminary fieldwork to examine the possibility and practicability of this research. My findings during the feasibility study supported my planning for the next stage of research. They confirmed that Zimbabwean migrant women were indeed facing serious health threats. Key informants, such as TAC officials, nurses at the Giyani Health Centre and randomly selected Zimbabwean migrant women, supplied the information. I thus discovered that migrants are excluded from state health services. This finding paved the way for a more sustained examination of the problem under review.

I conducted the main fieldwork for this study over two months from January

to the end of February 2017. I used qualitative methodologies to interrogate Zimbabwean migrant women's reactions, experiences and responses to their exclusion from the public health services. Qualitative studies take an interpretive approach to social life and analyse the lived realities of social actors (Neuman 2003). This approach enabled the study of the social life of migrant women and permitted me to look through their lenses. I reviewed various stories in which migrant women were successful and unsuccessful in accessing healthcare services.

I made use of my pre-existing social networks with Zimbabwean families in Giyani and with the TAC, with whom I have worked in the past, to identify individuals, families and households as research participants. The migrants I already knew led me to other migrants. I selected Dzumeri, Homu, Section A and Section F in Giyani because these areas are densely populated with Zimbabwean migrants. I picked a total of 52 participants from these areas. These research participants were considered for participation throughout the period of research.

I used unstructured interviews to give migrants enough room so that they could explore their plight in accessing healthcare amenities. I thus drew on Minichello (1990) who notes that unstructured interviews are versatile in nature. This versatility allowed migrant women to reflect deeply on their vulnerability and adaptation to potential health threats. As interviewing married women could potentially lead to contestations from their spouses, where possible I interviewed the migrant women together with their spouses. As a speaker of Shona, the native language of many Zimbabweans in the Giyani area, the sharing of experiences was based on the mutual trust which our shared language enabled.

I also used focus groups discussions (FGD) during my fieldwork. Denzlin and Lincoln (2000) and Gibbs (1997) define a FGD as a group of individuals selected and assembled by a researcher to discuss and comment on personal experience and the subject matter. The FGDs helped me to address the lived personal experiences of migrant women with regards to healthcare access. I conducted three separate sessions. For each, I triangulated the information gathered from the discussion for validation. Follow-up discussions complemented the information initially supplied by the participants. Each session comprised 10 participants. I selected both men and women in order to balance the discussions. I repeated this procedure for all sessions and throughout the research period to maintain

consistency. This allowed male migrants to explain how they understood the health threats that their female counterparts encountered. It was also vital to know how migrant men and women were helping each other to off-set potential health threats. In addition, I conducted what in effect became informal focus group discussions with Zimbabwean nationals as we encountered one another in shared social spaces in Giyani. These are explored in the chapters.

Life histories allowed the exploration of migrant women's individual experiences of exclusion from healthcare within a macro-historical framework. Life histories provide a vision of alternation to empirical methods of identifying and documenting health patterns of individuals (Neuman 2003). They enabled a study of the health patterns and choices for healthcare exercised by individual Zimbabwean migrants, allowing each migrant woman to explain how she understood potential health threats that resulted from her exclusion from public healthcare. In this manner I managed to collect narratives of their experiences as a migrant group. The recording of detailed stories germane to the women's lived experiences was crucial to achieve depth in the data. It also allowed the women to explain the ways in which they were being excluded. This was critical since it permitted the women to explain the subsequent strategies they employed to transform their health situation for the better.

Selected key informants with whom I conducted formal interviews were drawn from NGOs that work directly with the migrants. These included TAC officials and activists; IOM officials; and officials from Anova, an NGO working with migrants in Giyani. I also interviewed leaders of CBOs and churches, and migrant representatives. All of these individuals painted a complex picture of how local institutions act as coping avenues, fostering resilience among vulnerable migrant women. I also selected them for their specialised knowledge about migrants and healthcare—indeed, some had been involved in previous research on this question (TAC 2014). In addition, I engaged managers and project coordinators from government institutions such as the Department of Health (DOH) and the Community Services Department as key informants. This allowed a discussion of the institutionalised exclusion of migrant women not only from the viewpoint of the victims but also from those who were believed to be the perpetrators.

Politics of the Field

The field was characterised by a challenging socio-political environment that shaped my fieldwork. I observed conflicting ideas between the DOH and the Department of Home Affairs. In terms of the National Health Act, the DOH is responsible for the health of all who live in the country, regardless of their citizen or migratory status. On the other hand stands the Immigration Act that warrants arrest and deportation of migrants without 'papers'. Therefore, migrants could not easily open up to participate in this research because of the fear of deportation. Indeed, some of the respondents were elusive, diffuse and undocumented which made it difficult to carry out my fieldwork. To off-set this problem, I lived in my research area and built up rapport with my research participants over time. When dealing with government officials, I was also confronted with hierarchies that sometimes delayed my interviews. For instance, government departments would require me to be vetted by several offices before I could engage with the targeted respondent.

Research Ethics

My research is informed by the Ethical Guidelines and Principles of Conduct for Anthropologists as issued by Anthropology Southern Africa, the professional association of anthropologists in Southern Africa (ASA 2005). To protect migrants' identities, I used pseudonyms. I also informed the participants that my research was purely academic. A student identity document and an ethical clearance letter from the University of Cape Town (UCT) where I was enrolled validated the academic nature of my research. I also sought advice from my supervisor upon seeing anything that I thought would jeopardise participants. To maintain my safety as a researcher, I sought advice from a TAC manager; in dubious situations I quickly evacuated precarious spaces. UCT's ethics committee alerted me to the possibility that, as an unmarried man working with women, some of whom were married, I would need to be sensitive to spousal relations, especially where husbands might not feel comfortable or could not understand the aim of the research. I carefully implemented their methodological recommendations to avoid such issues from arising, but in fact never met any challenges; if there were any problems with my research along these lines, they were not brought to my attention. This did not necessarily come as a surprise to me as I had done similar research in Tzaneen and

Giyani with the TAC before and had never experienced problems along those lines.

To protect my respondents and keep their dignity secure, as well as to respect their rights, I worked through the TAC that has long-established relations with migrants in the area. I understood that I was working with Zimbabwean migrant women and children who are away from their home countries. This informed the precarious nature of my fieldwork. It is expected of me as a researcher not to cause harm to the participants in particular and to people in general (Macdonald and Spiegel 2013). I assured my research participants that the research carried no danger to them that I could ascertain. I also promoted their privacy and confidentiality throughout the research. Participation of individual(s) was voluntary and based on informed consent. To protect participants' privacy and rights, consent was verbal and always was negotiated throughout the research. This helped migrant women in particular to understand why they were participating in the research and to evaluate whether there were any potential negative or positive consequences of their participation.

According to Denscombe (2010), as far as justice is concerned, a researcher's personal feelings should not affect the outcome of the research. This is difficult in social anthropology which embraces the subjective but discusses it openly in the narrative. I have tried to maintain impartiality since I was working with Zimbabweans with whom I share the same citizenship and cultural background. It is also ethical that research should make a positive contribution towards the welfare of the research participants. In line with this, I wrote a communiqué for the TAC on the findings of the study. I believe this communiqué will feed into the welfare of migrants and the TAC's on-going work on their behalf.

Organisation of the Thesis

Chapter 1 explores the justification and importance of the study. It describes the migration trends and the making of social networks and social capital by migrants, and considers the challenges they face. It also explicates the conceptual framework, methodology and study approach and introduces the field of study. Chapter 2 focuses on the lived health experiences of ordinary Zimbabwean women against the backdrop of the presence, and lack, of documentation. It focuses on the women's access to public health facilities before, during and after giving birth. Chapter 3

examines various adaptive and resilient strategies migrant women have improvised to cope with their exclusion from public healthcare. Chapter 4 examines how migrant women confront and off-set health-related threats. Chapter 5 evaluates the role of local institutions in building the adaptive capacity of vulnerable migrant women. It discusses the survival and resilience of migrant women and explores how local institutions act as coping avenues, fostering resilience. Chapter 6 concludes the study, identifying potential shortcomings of the work and proposing recommendations for future research to enhance the maternal health of migrant women. Drawing on Chabal's model of suffering and surviving, my research concludes that while migrant women suffer exclusion from healthcare, they manage to survive by using social networks as a means to an end. I argue that mediations and interventions should be both compatible with people's strategies and significant to foster practical survival and resilience amongst migrant women.

Chapter 2. 'On Paper' and 'Having Papers'

Introduction

The right to health is important to the mental and physical well-being of all human beings (Makandwa and Vearey 2017). This condition is necessary for the realisation of other human rights as well. In South Africa, migrant healthcare rights are covered in the constitution and by a number of international protocols to which the country is signatory. Section 27 of the constitution states that healthcare services and spaces should be available, economically sustainable and physically accessible to everyone on a non-discriminatory basis. In particular pregnant women and children under the age of six enjoy access to free healthcare, irrespective of migration status. Yet, regardless of this liberal healthcare and immigrant rights regime, migrant women remain excluded from health services. This is because they lack the proper documentation (e.g. residence and work permits) necessary to access state-provided reproductive healthcare. What is clear 'on paper' thus becomes considerably more opaque when experienced by those who do not have 'papers'. This chapter traces migrant women's engagement with public healthcare facilities before, during and after giving birth. The difference between what is 'on paper' and 'what papers migrants have' is critical. However, in some instances it can be mediated by access to other vital networks.

Migrant Women's Rights and Access to Healthcare

South Africa is signatory to several international obligations such as the United Nations' (UN) strategic development goals (SDGs). These obligate member states to address the health needs of women and children (IOM 2014). Despite these obligations, the health of mothers and children in South Africa remains poor. South Africa's maternal mortality rate is on the rise. Statistics provided by the World Health Organisation (WHO) show that it lay at 310 deaths per 100 000 lives in 2010 (cited in Ntuli and Ogunbanjo 2014). In the same year, the mortality rate of infants under the age of one was 41 per 1000 live births and 57 per 1000 live births in children under five (WHO 2010).



Figure 2.1: Map of Limpopo Province, with its districts marked in various colours, showing the location of Giyani in relation to South Africa's neighbouring countries. Source: Htonl [CC BY-SA 3.0 (<https://creativecommons.org/licenses/by-sa/3.0>) or GFDL (<http://www.gnu.org/copyleft/fdl.html>)], from Wikimedia Commons

South Africa has also committed itself to the resolution on the health of migrants as adopted by the World Health Assembly (WHA) in May 2008 (IOM 2014). This resolution calls upon member states to promote equitable access to health promotion and care for migrants. Member states should establish health information system in order to assess and analyse trends in migrants' health. States are required to develop mechanisms for improving the health of all populations. Apart from the above, the National Health Act of South Africa states that healthcare services and spaces should be available, economically sustainable and physically accessible to everyone on a non-discriminatory basis. All these proposed actions must include and meet the needs of the vulnerable groups, thus including migrant women and their children (Crush, Chikanda and Skinner 2015). This is based in Section 27(1)(a) of the Constitution of the Republic of South Africa, Act 108 of 1996. It states that everyone has the right to have access to healthcare services, including reproductive healthcare. The obligation of Section 27 is to respect the rights of migrant women and children and to assist the state in assuring that no healthcare practitioners deny this access to anyone (Makandwa and Vearey 2017). Nevertheless, migrant women and children face challenges with rights and access to

public healthcare in South Africa (Crush and Tawodzera 2011).

Distribution of Health Resources in Limpopo

Giyani has experienced a tremendous influx of migrants in the last three decades due to the fact that it is located close to South Africa's border with Mozambique, Zimbabwe and Botswana (see Figure 2.1). Because of the proximity to their homelands, Giyani has been a location of choice for a significant number of Zimbabwean and Mozambican migrants (TAC 2014). DOH reports suggest that the number of migrants in Giyani is growing. This means that the number of people who are likely to use public health facilities is increasing as well. On the other hand, the number of health practitioners in public health facilities in the town is declining due to the outward migration of qualified medical staff, significantly affecting the services offered there. For example, the outward migration of qualified nurses to bigger cities like Pretoria, Johannesburg and even out of the country is increasing the strain on the public health sector (Limpopo DOH 2016). This has resulted in a significant lack of qualified health practitioners which is influencing the distribution of healthcare in Giyani and in Limpopo Province at large.

In investigating the distribution of healthcare in Giyani, I conducted a focus group discussion with healthcare practitioners from Dzumeri Health Centre. I was introduced to this centre when I was invited to a Migrants' Health Forum meeting that took place there, which gave me a chance to discuss the situation with the nurses there. They explained that the distribution of healthcare is calculated in line with the number of citizens documented in the area it serves. One of the nurses explained that the Limpopo provincial government dispatches medication to government healthcare facilities using the documented number of citizens. This number is accumulated from those who are documented when they visit public health facilities. She said that the population in the health facilities databases thus reflects the number of 'citizens' only and does not account for migrants (see Table 2.1). She explained that:

Foreigners are not counted, especially when they do not possess any documentation. When foreigners come to the clinic, especially when they do possess any documentation, they risk not be[ing] recorded in the database. This means that the number that will reflect at the end

of each year when the numbers are consolidated reflects only that of South Africans [citizens].

The explanation provided by the nurse largely represents the consensus of opinion among the community members involved in the research. This indicates that government health procurement corresponds with the statistics of the citizens who are registered in their population database. It also means that undocumented migrants are not counted and, therefore, fall out of provincial healthcare planning and administration. In this manner, the provision and procurement of healthcare services by foreign nationals is narrowed due to their undocumented status. This exclusion leaves them vulnerable.




Table 2

Name of District	SA		Population Density (per km ²)	No of Private Facilities	Specialised Hospitals	No. of Fixed Clinics	No. of CHC	No. of District Hospitals	No. of Regional Hospitals	Tertiary Hospitals
	Population (Stats 2011)									
Vhembe District Municipality	21349	1294722	60,6	02	01 (Psychiatric)	11 6	08	06	01	0
Capricorn District Municipality	16988	261463	74,3	05	01 (Psychiatric)	96	04	06	0	02
Mopani District Municipality	24489	1092507	44,6	02	01 (Psychiatric)	95	08	06	01	0
Sekhukhune District Municipality	13426	1076840	80,2	01 * 0	0	84	03	05	02	0
Waterberg District Municipality	49504	679336	13,7	05	0	61	02	07	01	0

The heartland of Southern Africa - development is about people

Table 2.1: Distribution of hospitals, clinics and people (excluding migrants) per district in Limpopo Province. Source: Limpopo DOH report 2016

Entering Giyani



Figure 2.2: Welcome sign at the entrance to Giyani

Figure 2.2 shows a site locally known as Gaza Beef because of cattle farming that happens in the area. This is where the R578 from Louis Trichardt and the R81 from Polokwane via Tzaneen meet. These are the key routes used by migrants coming from Zimbabwe. At the entrance to the town, they are welcomed by a statue of women and children standing in front of a wall that carries the inscription 'Welcome to Giyani'. Flowers planted in front of the wall represent the hospitality extended to women and children by the authorities whose emblems are displayed on the wall below the inscription. The words 'Welcome to Giyani' themselves suggest that the authorities accept the presence of women and children with cordiality and pleasure. This reflects what is on 'paper'. Yet it is contested in practise. The right for migrant women and children to be in Giyani has become increasingly procedural. It is marred by institutionalised violence against those without 'papers'.

At this same intersection, the police stages spontaneous roadblocks targeting mainly migrants who do not have papers. They stop all minibus taxis. In some cases, there will be locals who may not have documents on them but can speak the local languages. In other cases it would be migrants who have or do not have documents. When migrants do not have papers but speak Tsonga, Venda or Sepedi fluently, the

police will scrutinise their clothing as signifying belonging or non-belonging. They expect locals to be wearing clothing brands such as Nike, Adidas or Converse. In contrast, they anticipate migrants to be wearing cheap outfits in line with their perceived status as poor, jobless, vulnerable and always repatriating people. So anyone identified as wearing cheap clothing is subject to further scrutiny, possibly even arrest or deportation. The right of migrant women to cross borders may not have been formally abolished yet (Mbembe 2017) but, as demonstrated by the increasing number of roadblocks at this Giyani intersection, is characterised by violence and discrimination, premised on documentation status.

Staying in South Africa is becoming increasingly procedural. Migrants feel that their rights can be suspended or revoked at any time and under certain pretexts (Mbembe 2017). At the same time migrant women's movement or mobility is reduced because they fear being identified by police during road blocks. This means that even when they fall sick, they may decide not to access a health facility for treatment, a story I heard repeatedly during my research. Similar scenarios are documented and explained by Mbembe (2017), building on a long history of regulation and restriction of migrants. He describes this as the militarisation and contraction of local borders, the tightening of rights and the extension of tracking and surveillance of people. Gaza Beef has become a sign of a tightened border that determines who is supposed to move in or out of Giyani. Through the erection of police roadblocks at Gaza Beef, the mobility for migrants is made difficult while that of locals is enhanced. Migrants with whom I spoke revealed their fear of being arrested and deported. They also expressed the fear of being publically outed as 'foreigners' as xenophobic tensions¹ in the area were heightened. Even though the horrifying violence against African migrants in May 2008 was not as prevalent in Giyani as elsewhere in the country, it nonetheless defined local interpretations. Given recent occurrences of violence against non-citizens in Polokwane and its surrounds that were framed by the media and the state as xenophobic, migrants were

¹ Francis Nyamnjoh (2006) documented and explained similar, everyday life forms of xenophobic tendencies (2006). He explained that, in South Africa, 'makwerekwere' or 'foreign maids' are constituted as strangers, outsiders and aliens of the nation state, based on race, ethnicity, gender and class.

guarded about being too openly identified as non-nationals. In addition, they described subtle but no less pernicious forms of discrimination, such as in relation to access to healthcare to which they are legally entitled. Crush and Tawodzera (2014) describe this as medical xenophobia.

Manifestation of Medical Xenophobia in Giyani

Medical xenophobia refers to the negative attitudes and practices of health professionals and employees towards migrants and refugees based purely on their identity as non-South African (Crush and Tawodzera 2014: 655).

During an unstructured interview, Shuvai, a migrant woman from Zimbabwe, told me that she had once been a victim of what, in terms of the definition above, could be characterised as medical xenophobia. She had gone to Nkhesani hospital to give birth to her second child. The nurses took a hostile attitude towards her and stereotyped her, together with other Zimbabwean women, as ‘people that bring diseases to South Africa’. Most of the time she was denied treatment. In cases where she accessed assistance, it was accompanied by verbal attacks including denigratory names like *makwerekwere*² or ‘border jumpers’. She reported how she was told that Zimbabweans ‘flood hospitals’ and ‘exhaust medications’. What hurt her most, she said, was when she was told that she was a foreigner who was not supposed to be in South Africa. She recorded how a nurse at Nkhensani hospital said:

N'wina maZimbabwe makwerekwere mi tisa mavabyi la South Africa, kahle kahle mi lava yini? Tlhelalani eka Mugabe a hi mi lavi laaa..! (You Zimbabwean *makwerekwere* bring diseases and illness here to South Africa! What exactly do you want? Go back to Mugabe, we don't want you here..!)

These words caused Shuvai to feel disheartened; she had at least expected a nurse to communicate with her as a patient regardless of her not being a South African. Shuvai observed that South Africans were not treated as badly as were non-

² *Makwerekwere* is a South African slang word for foreigners.

South Africans. Other migrants, both men and women, with whom I interacted frequently described experiences similar to Shuvai's, indicating that medical xenophobia is rampant in South African public health facilities. In this manner, they confirming Crush and Tawodzera's findings.

It emerged from my research that medical xenophobia manifests itself in various forms. The negative attitude towards migrants, and particularly towards women, is unveiled when the healthcare practitioners stereotype them as a population 'flooding' health facilities in South Africa. Crush and Tawodzera (2006) note that two thirds of the South African nationals who participated in a nationally representative survey by the Southern African Migration Programme (Black, Crush and Peberdy 2006) were of the opinion that foreigners exhaust South African resources and bring diseases with them when they come to South Africa.

In further discussions of this issue, Pauline, a mother of two from Chiredzi in south-eastern Zimbabwe, described situations where doctors prescribe caesarean sections for pregnant migrant women solely because they are not South African and have no papers. She said that when doctors in public health facilities engage with migrant women, they insist on caesarean sections without properly examining the patients. She felt that this is covertly exercised by doctors who do not feel cordiality towards migrant women. Pauline was very aware of the fact that healthcare practitioners are supposed to be providing comprehensive and clinically professional services to all of their patients, including migrants. This interview with her reveals that medical xenophobia is a common occurrence in Giyani. Pauline explained the treatment she received as follows:

I had a challenge when I was pregnant a year ago. I was prescribed a caesarean birth solely because I could not produce documents that indicated my right to be in South Africa. I went to the hospital when I was in labour. I was asked to produce documents which I was not in possession of. I was kept waiting for five hours to be attended to. Eventually when the practitioners seemed to have served all other patients who appeared to be citizens they finally attended [to] me. When I was admitted into the theatre, the doctor seemed to be exhausted and ready [to] knock off. After the doctor realised that I

was a Zimbabwean, immediately without further examination the doctor prescribed me a caesarean section. I pleaded with them to wait because I knew from past experience that I had never had a C-section when I gave birth to my first-born child. It was during that negotiation period that my baby could not wait any longer. That's when the doctors reluctantly helped me to deliver without having undergone a C-section.

Zimbabwean nationals suggested that medical practitioners are biased against them. 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 my research is that there is a widespread perception among migrants that state officials perform unnecessary C-sections on migrant women; that is, the South African state is routinely involved in obstetric violence against migrants despite its commitment and legal obligation to supporting pregnant women, mothers and infants. As Chekero and Ross (2018) put it, there is no clear evidence of a systematic skewing of C-sections in relation to migrants, although this may be the case: C-section rates across the country are unacceptably high, and it could well be that what migrants experience as targeted intervention is part of a larger picture of over-intensive surgical intervention. In fact, there are some statistics that indicate that Limpopo Province, with which I am concerned, has a lower C-section rate than the larger metropolitan provinces (Monticelli 2012), even though the rates are still above those recommended by the WHO. Both in the research for this project and in my earlier work with the TAC, many Zimbabwean nationals shared similar stories of medical exclusion and routinised humiliation encountered when trying to access public health facilities in South Africa, especially when they are 'without papers'. This correlates with Makandwa and Vearey's (2017) study of the maternal health experiences of Zimbabwean migrant women: they indicate that for those who are able to successfully acquire health services, the experiences made in the process are usually negative.³

³ Recent news reports offer further anecdotal evidence of such claims. For example, *IHarare* reported on 5 June 2017 that Francine Kalala gave birth on a train after

‘Papers’ are Central to Healthcare Access

‘Papers’ are key to accessing healthcare. Papers here refer to documentation that shows the right of migrants to be in South Africa. These include but are not limited to residence permits, work permits and visitors’ visas. Most migrants with whom I worked have Zimbabwean passports, but these are regarded invalid by South African authorities because they lack permits. When Zimbabweans want to enter South Africa without a work permit or a residence permit, they are given 30-day entrance visas by South African immigration officials at the border. In some instance they need to travel back to the border to renew their visas. Yet, most of the research participants said they rather chose to have their passports reflect (incorrectly) that they are in Zimbabwe so that they could avoid the monthly travel back to the border. As we saw in the opening paragraphs to this thesis, people use a variety of strategies to circumvent onerous border controls.

During a focus group discussion with Zimbabwean women in Giyani’s Section F, the women said that South African Immigration officers at the border gate usually granted them visas that were valid for only a few days. This had negative effects on those lacking work or residence permits, as they would need sufficient time for job-hunting. Often the few days granted were not sufficient to find and secure a job. As with Yvonne, whose story opened the thesis, migrants described how they remained in South Africa covertly. Some described bribing immigration officials. Others made use of different networks. Migrant women acknowledged that access to South Africa was controlled at the border and depended on the type of travelling document the migrant possesses. However, upon settling in South Africa, they encountered additional challenges, often similar to those encountered at the border. This indicates the fractal nature of state power and bureaucracy, in which the arrangements at the national set of borders are replicated in miniature at other levels (state institutions).

In further probing this subject, I conducted an additional focus group discussion with Zimbabwean migrant women. This discussion revealed that the lack of papers makes migrants vulnerable to arrest and deportation. The fear of being

having been turned away from three South African state hospitals because she lacked papers.

deported thus limits their movement: migrants were cautious of exposure to agents of the state, even when this came at the cost of their own well-being. Thus, even in the event of falling sick, migrants are unlikely to visit public health facilities due to their lack of documentation that would legitimate their stay. As an adaptive measure, the majority of them said they live in ‘silence’ and ‘secrecy’, limiting their movements and engagement with offices of state authorities. From the perspective of the state and its representatives, they thus become invisible individuals. To maintain this secrecy, the migrants need to reduce their visits of public hospitals, clinics and even police stations. The majority of participants expressed vulnerability due to a number of factors, but the most commonly noted is limited health services as a result of their migratory status. Migrant women in Giyani expressed the desire for *kunyarara* (silence) and secrecy in order to achieve safety from arrest and deportation. In one of the focus group discussions, migrant women from Section E and Section A in Giyani, which lies close to the centre of town, expressed that they live in constant fear of police and Home Affairs officers. One of them indicated:

Tinotya kusungwa kana kudzoserwa ku Zimbabwe. Kugara takanyarara uye tisingazivikanwe kuti tiri maZimbabwean ndiyo nzira inoita tirame (We are afraid of being arrested and deported to Zimbabwe. Remaining silent and living in secrecy is the only way we can survive).

This quote largely captures a consensus of opinion among migrant women. Living in this way means that they cannot access the healthcare system. This affects their health and well-being in that they cannot receive treatment in acute cases or preventive medication. Migrant women said that in order to make, shape and maintain their ‘invisibility’,⁴ they have also embraced local dress codes as a strategy. As I have shown earlier, local people are generally identified as those who wear expensive labels, such as Nike, Jordan, Adidas, Converse or Dickies. The women confirmed this, stating that non-citizens are generally identified by the cheap outfits they bought from ‘China shops’.⁵ In order to blend in and not be labelled non-

⁴ Invisibility refers to migrants living unnoticeable to the authorities.

⁵ China shops are shops owned by Chinese believed to be selling cheap and low

citizens by the authorities, migrant women stated that they had begun to buy the same expensive clothing brands as the locals were wearing. In this way, they try to fit in and avoid scrutiny by the authorities such as the police.

A key informant, an official from the Anova NGO, confirmed that the lack of papers limits migrants' access to public healthcare. He noted that government had put little effort in place to address this exclusion. For example, he said that there have been many cases at Nkhensani hospital where the healthcare practitioners had deliberately denied migrants access to their services solely because they lacked documentation. Even in situations where migrants knew that they had the right to access healthcare, they were still not able to claim them. This is because people in lower positions of power, such as the security guards or nurses, are able to exercise the power of excluding migrant women. Anova has documented reports of numerous migrants who have tried to exercise their rights but have routinely been dismissed by healthcare professionals. Healthcare practitioners, especially in government hospitals, are known to turn migrants away without treatment because of their lack of papers. The official commented that it was in particular nurses who were hostile and did not receive migrants hospitably. In most of the cases that Anova and the TAC recorded, migrant women who did manage to give birth in these hospitals described the shockingly bad treatment they received there. The Anova official commented on the bad treatment as follows:

Sometimes migrant women are not attended to or they are given student nurses to attend them, which is risky. The challenges migrant women are facing is management oversight, where the management is failing to employ checks and balances on policy implementation on the ground.

Such episodes of medical exclusion and hostile reception of female patients are a common occurrence in South Africa. It correlates directly with Chabal's (2009: 153) description of calculated violence in the medical sphere, which he describes as 'the deliberate failure of governments and state officials to carry out their duties'. This state of affairs worsens the health shocks and risks of migrant women, especially those that are pregnant or those with children. Women need to be able to

quality products.

engage with the healthcare system frequently in order to receive antenatal care, vaccinations of their children, treatment of illnesses in themselves and their children, and family planning treatment. Denying them access to treatment severely compromises their health and well-being and that of their children.

Conclusion

Despite the welcome that Giyani's entrance purports to offer to incomers, this chapter shows 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. Medical staff read the lack of papers as a sign of not-belonging. Their responses vary from neglectful to outrightly hostile. Forms of medical xenophobia abound. These are apparent in the treatment migrants report and also in their fears—as for example those medical practitioners who by principle only give C-sections to Zimbabwean women, or those who do not even permit them entry into a healthcare facility. Access difficulties are compounded by the ways that migrants slip beneath regimes of visibility as they seek to go about their everyday lives.

Chapter 3. Coping and Adapting to Health Threats

Introduction

Zimbabwean migrant women possess a wide range of social networks as coping strategy against exclusion. For this, they invest in co-reliance or collective action. By relying on mutualism or co-reliance, or what I call ‘collectivism’, migrant women are in a position to negotiate exclusion from healthcare and to navigate life in Giyani. This collectivism helps vulnerable Zimbabwean migrant women spread the shocks and stresses that result from being refused access to a variety of social services. Migrant women cultivate various types of networks: savings and grocery groups, burial societies, friendship networks, and marital relations, among others. Cultivation of networks is premised on what Nyamnjoh (2017) describes as ‘conviviality’. This is the ‘pursuit of sameness and commonalities by bridging divides and facilitating interconnections’ (Nyamnjoh 2017: 263).

Collective action affords migrant women a position to detect health-related threats and plan to adapt and mitigate such risks (Uphoff 1997). Most migrant women confirmed using marriage as a strategy to create and sustain social bonds that would translate into social capital that, in turn, would allow them access to health services. Social networks are essential in fostering migrant women’s belonging in South Africa. Relating to that idea, Nyamnjoh (2017) upholds that social networks are vital for migrant women as they bring unity by bridging divides and facilitating interconnections among migrants and the host community.

It is important to note that social networks are premised on social capital. Social capital is transformed into vital relations that are pertinent in accessing healthcare. Putnam (2000) best articulates social capital in three axioms of bonding, bridging and linking. Bonding relations are when migrant groups are brought together by similar socio-demographic traits that include culture, tribe, race, nationality or ethnicity. Bridging relations, in turn, are embraced especially by vulnerable migrant women as coping mechanisms to adapt to health threats. Third,

interdependence and interlinking relations help migrant women to address health and pregnant related health challenges like parent to child transmission of HIV/AIDS, STIs, malaria, and tuberculosis, among others.

Marriage and Social Capital: Coping and Adapting to Challenges

One day after a church service at a local church called the Conquerors Ministries, I discussed the role of marriage in survival strategies with a group of women. Some of the Zimbabwean women said that they had left their spouses back in Zimbabwe. Some explained that they are single parents running away from political and economic persecution in Zimbabwe, looking for better living conditions in Giyani. All described marriage as a dependable strategy they were utilising to develop and sustain social bonds in adapting to health threats. They saw marriage as ‘linking capital’ that connects them to South African health resources. As officially married women, they acquired marriage certificates which are recognised by the state as legal documentation and accepted by the local community. Their choice of residency, immediate local connections and benefits in their economic and health situation matter most. Zimbabwean women maintained that marriage allows them to benefit through their South African husbands as they can smoothly access to health and other state-provided services.

The majority of the migrant women emphasised that, when they chose to live in South Africa, they either established homes to stay here permanently or married temporarily. Temporary marriage is regarded as cohabiting (*kuchaya mapoto* in Shona). Even though these marriages are legal and are documented by a marriage certificate, the women do not consider them as proper marriages because *lobola* (bridewealth) has not been paid. The marriage, thus, does not meet the ideal form of a marriage. Such transnational marriages (Nicola and Mina 2003) that do not involve *lobola* payment are not recognised as such by the society. Pauli and van Dijk (2016) posit that the marriage process is often not linear but instead resembles a continuous mix of movements, exchanges and temporalities during which relationships can be deepened, dissolved or renegotiated. Drawing from this, some of these relations will be classified as marriage and others not. Many of the relationships in this case can be classified as paradigms of calculation with locals seeing them as marriages and migrant women as cohabiting relations. However, migrant women do not openly

admit that ‘tiri kuchaya mapoto’ (we are cohabiting). Publicly they present their relationships as official marriages by using the word ‘takaroorwa’, which means ‘we are properly married’. The Giyani community accepts this type of marriage especially when there is a child bonding the union. Children are the bond that makes the marriage intact and authentic. Yet, when on their own or with other Zimbabwean women, some will say that they are cohabiting because, sooner or later, they will return to Zimbabwe.

In some instances, migrant women do not plan to spend the rest of their lives with their South African partners. In such situations, they called their husbands ‘chikomba’, a word for lover carrying negative connotations and in this case referring to a husband who has not formally paid ‘lobola’. The word cannot be used by a woman married under customary law in Zimbabwe. This is usually because, as they note say, ‘vabereki vedu havana kupihwa pfuma,’ (our parents have not received bride wealth). The fact that the marriages of Zimbabwean women are accepted in Giyani as proper marriages but are considered as cohabiting relationships in the wife’s Shona context because lobola has not been paid results in tensions. It would take a lot of time and significant effort for a Tsonga man to travel to pay ‘roora’ (Tsonga for *lobola*) in Zimbabwe to the woman’s natal family. This tension works in the woman’s favour, as she is able to use her locally recognised marriage to secure rights for herself and others, while she is not fully obligated to the form of marriage that is recognised as enduring in Zimbabwe.

During the discussion, Zimbabwean women expressed that their choices are limited by the economic hardships in Zimbabwe. The women said that those who are not engaged in *kuchaya mapoto* and those who have no capital or other means face significant difficulties in accessing healthcare and various other social services. Women who are married to South African men confirmed that they were using marriage as a strategy to achieve a legitimate citizen status in South Africa. Those married to South African men can obtain permanent residence permits or identity documents and become legal in the eyes of the state, even if not quite legitimate in the eyes of their kin in their places of birth. Marriage is the bridging and linking strategy that connects migrant women with offices of authority. In this regard, migrant women use marriage to obtain papers and gain access to resources, health services and other social service needed for human well-being. Most marriages of

this kind are solemnised in churches and marriage certificates are issued. After the marriages, the women use their marriage certificates to negotiate the process of 'paper acquiring'. In this they are accompanied by their South African spouses. While the process can take time, the women explained, eventually they are granted the papers. This in turn opens up new avenues and opportunities, such as access to social services and jobs, and to salient health services for themselves and their children. My findings are similar to those of Pauli and van Dijk (2016) who found that long-distance labour migration has led to changes in the form of marriage. They note that the focus of marriage has shifted from one on the exchange of wives per se to one on the exchange of babies and benefits between South African men and Zimbabwean women.

The situation is demonstrated by Rhoda's story. Rhoda recounted that she came from Zimbabwe in 2009 to look for work. Prior to that, she had crossed the border solely for trading purposes. When she first came to Giyani for work purposes, she met Khulani, a Tsonga man, when she was stranded and had nowhere to sleep. Khulani took care of her and gave her a place to sleep. This is how their relationship started. In 2011 they married at a local church. They acquired a marriage certificate which they later used to acquire a temporary residence permit for Rhoda. It was a drawn-out bureaucratic process, but she eventually got her permit. Rhoda explained that the priority to her had not been to be recognised as a married woman by the state but the benefit that came out of the formalised union. With her papers, she can now access job opportunities and health services. She has found a job and sends money and basic goods back to her natal family in Zimbabwe. She has open access to healthcare services as she can always produce her documents when needed. Her situation is of benefit not only to herself but she is now able to use her connections to help other migrant women. When necessary, she will go to the hospital or clinic to get medication for them. One research participant described the reason for marriage as the gain amassed out of the union and not merely love and commitment. Yet some revealed that they may end up feeling emotionally attached to their spouses.

In a subsequent discussion with seven Zimbabwean women and a TAC activist at the popular Dzumeri Four Way Stop meeting point, I discovered that most Zimbabwean and other foreign women are quick to embrace *kuchaya mapoto* as a bridge that connects them to health resources. Not only does such a relationship give

them access to the papers that open up the gate to state resources, but their South African male partners become their mouth pieces when communicating their health challenges to the officials of the DOH. Migrant women are thus drawing on patriarchal power as a way to make their experiences heard. One of the women said that when representatives from the DOH, Social Development or NGOs come to have *imbizos* (community dialogues) in Giyani, their South African husbands would represent them and report how their wives are badly treated in public hospitals.

Migrant women confirmed that marriage can have positive consequences when accessing healthcare. They spoke about the nurse in charge at Dzumeri Health Centre who was known to turn migrants away without treatment. This nurse was transferred after the women's male partners filed a report to the authorities. Because departments at district and provincial level contribute to policy making at provincial and national level, local entities of the DOH are in a position to take these grievances to higher levels of authority and cause the implementation of policy changes. Migrant women confirmed that they are in a position to communicate their health challenges and to be equally represented in policy decision-making that affects their health access.

During the same discussion, it emerged that marriage transcends enabling access to healthcare and other social services. Migrant women reported that often their husbands would be the ones to go to the clinic or hospital with an ill child. Usually, taking care of babies and children, such as taking them for their vaccinations, is seen as a 'feminine' job within society. Yet, these South African men who have married Zimbabwean women understand that their wives are excluded from accessing health services. In these situations, the husbands would accompany their wives to health centres or go with their child, especially in situations of a pending or serious threat. One of the women explained her experience in this way:

We were turned away several times at Dzumeri Health Centre simply because we are Zimbabweans. However when we go with our husbands, we get all the necessary care and treatment because of our husbands who are South Africans.

Such sentiments represent consensus of opinion among the migrant women with

whom I worked. This means that the South African husbands are acting as the linking capital, connecting their Zimbabwean wives to health facilities.

A further example was offered by Linnet, a woman trained in Zimbabwe as a nurse and married to a South African man. During our conversation, Linnet described *kuchaya mapoto* as one form of marriage that connects migrant women with health-related and economic benefits. She owns a spaza (tuck) shop and explained that her husband secured it for her. She explained that her family members can visit her from Zimbabwe. Her husband will be obliged by the social bond and moral obligation to look for work for them and introduce them to the local community. Linnet described the benefit that comes with marriage when she illustrated how she and her husband send money to Zimbabwe and to her in-laws in Mapayeni (rural village approximately 40 km out of Giyani town) to maintain their status. They also send groceries and medicines back in Zimbabwe with *malaichas*¹ (transporters) or pay holiday visits to her natal home. Her *amai nyakutumbura* (biological mother) is diabetic and she sends her medication every month. To ease the economic hardship faced by her family back home, she usually calls her sisters to come for *maricho* (piece jobs). She herself eventually got a job as nurse in Tzaneen.

The bonds and obligations created through marriage are strong and inevitable: as we have seen, intimate relations generate social networks that can become social capital that then affords other people opportunities. Indeed Linnet confirmed that she uses her skills as a nurse to help fellow Zimbabwean women, And Zimbabwean women confirmed that they rely on bonding capital that allows them to benefit from Linnet. On many accounts, Linnet helped those who delivered their babies at home with treatment and her skills. Some women confirmed that they have received help from Linnet. In exploring social capital, it was evident that bonding relations are crucial. Survival is fostered through this manner of accessing health and related services. As I have illustrated, when one migrant woman is inside the system and has established connections, she becomes an asset instrumental in helping others. She then provides others with a place to stay in when they come from Zimbabwe and links them into her social network. Intimate relations thus produce

¹ *Malaichas* are Zimbabweans who offer unregistered courier services from South Africa to Zimbabwe.

social networks that can become social capital that then affords vital opportunities to others. By ‘vital’ here I mean to draw attention both to the necessity of these relations and also to their role in sustaining life (i.e. vitality). This demonstrates the pivotal nature of marriage and reciprocities that are instrumental to navigate health challenges and sustain life in the ‘diaspora’.²

Conviviality, Social Networking and Co-reliance: Coping with Health Threats

Migrant women make use of bonding relations to legitimate and regularise their belonging. Through networks lubricated by conviviality, migrant women gain access to healthcare services and other social services. Nyamnjoh (2017: 264) argues that ‘conviviality is maintained by a sense of community affirmation through network-based relationships.’ It has also been noted that social networks are one way in which migrants reduce costs of living and healthcare, and increase their expected returns and well-being. Among Zimbabwean migrant women in Giyani, social networks are spoken of as *hushamwari* or *husahwira* in Shona and as *ubungane* in Ndebele. The characteristics of *hushamwari* or *husahwira* and its culture shape the connections that migrant women use to adapt and facilitate resilience. Conviviality bridges divides and facilitates interconnections that help migrant women to link and bond despite diversity in demography.

As my research demonstrates, migrant women associate with each other in local social gatherings such as kitchen tea parties, baby welcome parties, *mukando* (money rotating scheme) meetings and burial societies to form cooperative groups. In these groups they learn to navigate through the complexities of everyday life in Giyani. They help one another socially, economically, in health-related matters and otherwise as an assured way of survival. Such associations enable migrant women to carefully negotiate and mitigate potential health threats. They also allow the women to bypass exclusion resulting from their migratory status, and they foster cohesion and unity. They create relations that the women later transform into linking capital that, as I have shown, connects them with a range of service networks.

During an unstructured interview with Madhube, a Zimbabwean woman, I

² Diaspora refers to the living beyond home borders.

noted that she was wearing a *xibelani*, a traditional outfit that is commonly worn by Tsonga girls and women during special ceremonies. A highly symbolic outfit, Madhve chooses it for very selective dancing ceremonies. Rangoonwala, Sy and Epinoza (2011: 232) argue that ‘dress code in one’s sense of group belonging may be a crucial factor in adjustment as he or she adjusts to new social environments.’ Thus, wearing what is considered traditional Tsonga dress is one way in which Zimbabwean migrant women can show their host community their belief in and adherence to local norms and values, concurrently legitimating their belonging. Madhve said that once the community sees her wearing a *xibelani*, they understand that she has accepted to become part of them. In this way she confirmed that there is a bigger possibility of smoothing her stay.

Madhve described relationships as social bonds that are sustainable in allowing access to healthcare. She expressed *hushamwari* as more than mere friendship. She said that it generates a sense of oneness and commonality with influential people like nurses and doctors. She went on to say that with *hushamwari* it becomes easy for her and other women to access health services in time of need. She confirmed that it is made easy by the social bonds and relations created when they meet with nurses in kitchen parties and at the *mukando* meetings. In her five years of living in Giyani, she has created a *hushamwari* with Tsakani, a nurse at Giyani Health Centre whom she met at a traditional ceremony. Tsakani was attracted by the way the *xibelani* fitted Madhve. This sparked a conversation between the two from which a connection developed. Tsakani brings her medication, knowing that just like many other migrant women Madhve could be turned away at the health facility. To maintain the *husahwira*, Madhve explained that they buy each other gifts, and attend parties and gatherings together. These in turn open up new opportunities. *Hushamwari* is thus a dependable asset that affords migrants solidarity and mutualism.

Whether one is with or without papers, connections are very vital. Borrowing from Schelling (1856–1861), the concept of vitality relates to the power of giving continuation to life. As I have demonstrated above, vital connections generated by migrant women are regarded as strong and active relationships between them and the local community that works towards fostering individual and collective well-being. These enable cultivation of networks in order to create resilience and adaptation, and

to mitigate health threats. As Nyamnjoh (2017: 264) argues, ‘the strategic cultivation and maintenance of networks enhances conviviality in significant ways.’ This is true especially for the migrants among whom I worked. They are from different backgrounds and origins but they are compelled to adapt, fit in, flourish or survive in their diversity. The relations made are instrumental in accessing healthcare and other social services.

Let me give an example. One Sunday afternoon I had an impromptu focus group discussion at Dzumeri Four Way, at a braai facility owned by a fellow Zimbabwean called Respect (see Figure 3.1). The group comprised of male and female participants. Two Zimbabwean women who had come there to buy meat also ended up joining the discussion. Even more women ended up joining as the discussion became captivating, not least because it was held in the shared Shona language. Most participants in this discussion described sociality as a crucial tool, especially when accessing healthcare. The women said that they rely on the benefits of sociality to negotiate ill health, exclusion and resentment. They expressed that churches, especially the Conquerors Ministry in Dzumeri and the Saints Ministry in Section F, are platforms where migrants create and sustain social bonds with the locals who attend. It is at these churches, the migrant women indicated, that they meet healthcare practitioners. It is here that they create relations to locals and maintain them. And the very same healthcare practitioners who have formerly denied them access to healthcare when the migrant women came to the clinics and hospitals would now provide access to healthcare at the church. Under covert arrangements, these healthcare practitioners would bring medication to church and give it to those with whom they had built up a *hushamwari* relationship. In the eyes of the community, *hushamwari* is based on social group gatherings and affiliations, but deep down that same *hushamwari* comes with benefits. This is how migrant women make use of vital connections to get access to healthcare. During the discussion one woman explained that:

We have nurses in our church whom we can make use of their services. When we get sick we call the pastor. The pastor will call the nurse for help. The pastor is respected, his request is not likely [to be] questioned.

These sentiments were shared by the migrant women with whom I worked. Because of the pastor's influence and the respect he commanded, nurses would oblige to help regardless of whether they were willing or not. The social capital generated here in church is thus inevitable: it connects those that are divided. It builds bridges and links people, spaces and places. It inspires imagination and innovative ways of seeking and consolidating the good life for all. Spaces like churches therefore facilitate associations between South Africans and non-South Africans. In a study of the Bay Community Church in Cape Town, where local South Africans and African immigrants worship together, Hay (2014: 42) argues that 'the church makes migrants feel at home away from home.' The space allows the negotiation of fears and misconceptions about non-South Africans.



Figure 3.1: Dzumeri Four Way braai facility, Giyani (I am second from right in the picture).

Churches in Giyani have become sites of transnational and local networks which migrants draw on for social and spiritual capital, emphasising a shared Christian identity and habitus (Nyamnjoh 2017). Such a shared platform allows migrants to create relationships that allow them to belong to various different spaces at the same time. As a result of a shared Christian identity and habitus, migrant women confirmed benefiting from the nurses with whom they worship together. They said that healthcare workers, under covert arrangements, invite them to their

homes for treatment. Migrants are therefore recognised as part of the social institutions, even as the formal institutions that are legally obliged to provide services exclude them. Thus the structure of social network ties between migrants and church opens up wide range of opportunities for integration and easy access to healthcare.

While attending the TAC's monthly provincial meeting in Giyani, I had a chance to talk to a number of TAC activists, some of whom are Zimbabweans. During the discussion the women said that they embrace *hushamwari*. *Hushamwari* generates linking capital that enhances the benefit of new ideas. In terms of linking, migrants have connections with organisations such as the TAC. Key TAC informants confirmed that many migrants benefit from various health interventions that the organisation provides. Migrants who are TAC beneficiaries also confirmed gaining a lot from interventions carried out by the TAC and its partner organisations.

The female TAC activists said that they rely much on social networks in order to gain the information they need to deal with health risks, shocks and stresses. The women explained that they only came to know about the 'Human papillomavirus' after attending a TAC community dialogue. Until then, they said, they had not known anything about the disease. They used such relations to access vaccinations against health threats. This exemplified linking relations where locals and migrants are connected with NGOs (such as the TAC in this example), churches and community-based organisations in fighting health threats like that posed by Human papillomavirus. During the discussion, the Zimbabwean migrant women expressed that they are able to gain access to current information, get assistance in dealing with health-related disasters, and to augment their resilience, energy and coping strategies.

Conclusion

Zimbabwean migrant women possess various social networks such as marriage and *hushamwari*, both lubricated by conviviality and sociality. Social networks which generate co-reliance are the most dependable strategy in adapting to livelihood and health threats. Through transnational marriages which are both recognised as marriages and yet also 'plausibly deniable', migrant women invest in co-reliance to deal with the challenges and threats to troubling their existence they face in Giyani.

Cultivating social networks is one way in which migrants boost healthcare access and increase their expected returns and levels of well-being. The characteristics of the social networks they engage in shape the connections that migrant women opt and co-opt to adapt to health threats. Despite the medical xenophobia that Zimbabweans feel characterises the medical sector, migrant women are able to craft social networks, lubricated with convivial relations, that create a sense of mutualism and co-dependence. These networks, in turn, generate access to resources such as medicines and healing techniques that might otherwise be unavailable. Results have shown the effectiveness of mutualism and social networks when the same healthcare workers who have formerly denied migrant women access would provide them through their membership of churches. Though social cohesion may be disputed among migrants and the host population, the social bonds made through mutualism, marriage and sociality appear to be strong.

Chapter 4. Turning on the Concept of ‘Danger’

Introduction

Apart from biomedicine, Zimbabwean migrant women also use traditional modes of health services and churches as strategies in coping with health-related threats. Migrant women are more likely to engage with healthcare services on a regular basis than men since they are responsible for their own health and that of their foetuses, their children and often also that of their partners. Their choice of modes of healthcare is influenced by their migratory status which, as we have seen, limits whether and how they access the state healthcare system. When they are excluded from this, they turn to churches and traditional medicine and healers. While their turn towards traditional healthcare might be forced by their migratory status, their openness towards it is embedded in Shona cosmology, so that even those that possess proper documentation will access it. Migrant women from Zimbabwe will also seek different forms of traditional and spiritual healing. Shona culture in Zimbabwe is very vital in the interpretation of how an illness is experienced and in determining which mode of healthcare should be applied. In other words, people adapt practices from repertoires they held in earlier contexts to these current, migratory contexts, drawing on what they already know and what they have come to know so as to fashion remedies particular to their new situations.

Zimbabwean migrant women rely on reciprocity and informal health-related information in terms of their health beliefs, behaviours or treatments. The women with whom I worked make use of Christian spiritual healing offered in Pentecostal churches to off-set perceived spiritual dangers. In spite of their belief in and commitment to Christianity, Zimbabwean migrant women live in fear of witches and other evil forces. The fear sometimes compels them to be overtly Christians while covertly frequenting traditional healers to off-set the dangers that they feel the church cannot address. The bargaining power that the use of both Pentecostal churches and traditional healers will grant has led some to use the two simultaneously.

While biomedicine deals with what it considers to be physical, biological

ailments or potentials, pregnant women take a wider range of agents into account in their quest to secure the well-being of themselves, their foetuses and their children. These include being attentive to physiological signs that might point to spiritual danger. These signs include but are not limited to dysfunctions of pregnancy, complications at delivery and health risks in children such as a sunken fontanelle (*nhova*) or birthmarks on the body such as *rigoni* (strawberry hemangiomas). The presence of these signs may be seen to point towards a vulnerability to forces beyond the body. To off-set these, migrant women take recourse in a range of practices, including visiting traditional healers and using traditional medicines. Others draw on Christian spiritual ideas about healing and many draw on both approaches simultaneously. While this might be characterised as medical pluralism, it is also the case that naming it such reinstates a concept of ill-health as a purely medical phenomenon rather than as a spiritual matter. Zimbabwean migrants, like those in their host communities, do not always draw such rigid distinctions.

Unpacking the Concept of ‘Danger’

Baxter (2014: 1) describes physical danger as ‘any hazard, condition or activity that could reasonably be expected to be an imminent or serious threat to the life or health of a person exposed to it.’ In this chapter, I describe forms of danger that go beyond the threat to physical health or life. Some dangers are rather what can be termed metaphysical issues. My participants described them in terms of demons, spirits and *mweya yetsvina* (evil spiritual forces). This belief is a common occurrence among Shona people. It ordinarily translates into the embodiment of cultural knowledge important for survival and well-being in the society. Such forces may become attached to Zimbabwean women or their families (see Nhemachena 2017). Among the Zimbabwe migrant women with whom I worked and some locals of Giyani, these forces can be linked to health and pregnancy-related threats such as dysfunctions of pregnancy or delivery complications. Pregnancy is particularly vulnerable to these forces because it is believed to be a liminal state in which a woman’s vulnerabilities are heightened, resulting in danger. Drawing on van Gennep ([1908] 1960) and Turner ([1967] 1987), pregnancy is viewed as liminal, a space between social structures. This approach provides a framework for understanding Shona experiences and understandings of pregnancy. As a major life transition, pregnancy significantly

impacts a woman's physical, psychological and social self. The pregnancy itself can make women vulnerable to health threats that in some cases result in death. In the biomedical system, this is indicated for example—as I was told repeatedly by Zimbabwean women with whom I worked—by pregnant women being advised not to take in certain types of medicines or foods¹ as this would compromise their health and that of the unborn' (cf. Côté-Arsenault, Donato and Earl 2006). Whilst biomedicine is embraced to deal with present or potential biological illnesses, pregnant women draw on a diversity of modes of resilience against illness, for them and their unborn babies.

***Nhova* as an Indicator of Spiritual Danger**

In Shona cosmology, *nhova* (sunken fontanelle) is interpreted as being linked to *nyoka* or *ruzoka*, which refers to an invisible snake that lives in the body until one dies. All Shona people are believed to be born with *nyoka*. It is a phenomenon that is not visible even when the body is dissected. Its presence can only be established through sensations when it is disturbed (Desai et al. 2014). For example, if a person ingests bad medicine or impurities, or faces a potential danger that could have invaded the body, the *nyoka* contracts and causes cramps or makes noises and moves in the stomach. It cleanses the body by causing diarrhoea to get rid of impurities in the body. When a child is exposed to both biomedical and spiritual dangers or impurities, as when it is bewitched or gets in contact with a potentially dangerous person, the *nyoka* pulls down the child's fontanelle by moving downwards in the body, hence causing a 'sunken fontanelle' (Desai et al. 2014). Diarrhoea is a common symptom of an infant suffering from a sunken fontanelle, both physiologically and in spiritual realms. The biomedical explanation for this lies in dehydration. In Shona cosmology, the link is less causal: the combination of *nhova* and diarrhoea is read as an indication of bewitchment. When such an instance arises, older, experienced women would say, 'Nhova yemwana yawira pane ashinha kana ashereketa' (the child's fontanelle is sunken; someone has bewitched him/her). The Shona thus read the affliction not simply as diarrhoea but as a physiological sign for

¹ Zimbabwean women are advised by doctors or experienced, elderly midwives not to eat foods such as sushi, sea food, eggs, caffeine and certain medicines.

spiritual danger. It may require traditional healers and medicines and recourse to religious ideas about healing to get rid of this threat.

***Mweya Yetsvina* as an Indicator of Danger**

Migrant women resort to ethno-medicines or solutions in dealing with diseases such as *nhova*. Even more closely connected to their choice of healthcare are spiritual risks like *mweya yetsvina*. The Shona expression of *mweya yetsvina* can be translated as the manifestation of ‘evil spirits’ (Nhemachena, 2017). Nhemachena (2017) argues that ‘spiritual forces’ are realities in men and women’s existence, of which, it can be argued, the spiritual side of people seems the most important as it appears to rule their lives. In the Shona belief system, the observance of spiritual forces regulates life, health and well-being. For the Zimbabwean migrant women, such regulation is suggested by the health threats they face, which in turn influences their choice of healers and their spiritual ideas about health, healing and well-being. For migrant women, fear of *mweya yetsvina* suggests the presence of danger. This may coerce them to consult Pentecostal churches. The Pentecostal churches in Giyani claim to have the ability to sniff out and exorcise *mweya yetsvina* from congregants. As I went about my field work, I observed that some Zimbabwean migrant women only consult churches on Sundays when they need spiritual and physical help upon facing spiritual or physical threat. Throughout the week, they frequent traditional healers or rely on biomedical medication and pharmacies for care. As Nhemachena (2017) demonstrates, this diversity of healthcare modes against illness also embedded in the everyday life modes of engagement and different ways of sensing danger.

***Rigoni* (Strawberry Hemangiomas) Indicating the Presence of Spiritual Danger**

When asking for examples of dangers faced by infants and how these can be off-set, Zimbabwean migrant women told me about *rigoni* (Tsonga for strawberry hemangiomas). In the biomedical context, such birthmarks are described as non-cancerous and clinically harmless skin lesions in which genetics are assumed to play a role, likely to fade with time and not requiring any treatment (see, for example, Limpopo DOH 2016). In contrast, they are interpreted with considerably more concern by the Zimbabwean women with whom I worked. For the migrant women in

Giyani and the Tsonga among whom they live, *rigoni* is believed to be caused by witchcraft and evil sorcery. Lebesse, Netshandama and Shai-Mahoko (2004), working among Tsonga people in Limpopo Province, note that *rigoni* is considered to be a disease. Biologically, the strawberry birthmark appears during the first few weeks of life. It does not necessarily need treatment since there is a remarkable tendency for this lesion to lessen and disappear on its own. In my experience, in Zimbabwe such birthmarks are not understood to have threatening qualities, a point confirmed by Zimbabwean migrants when reflecting on their knowledge of traditional signs at home. Tsonga people in South Africa, however, interpret them as an indication of forces beyond the body and a sign for witchcraft. The migrant women expressed that children born in Giyani should be protected (traditionally immunised) against such potential dangers and threats. Usually they identify *rigoni* when a baby is weak, does not want to feed, suffers from high temperature and has clotted blood veins at the back of the neck. Elderly, experienced women and traditional healers are customarily consulted for treatment in such cases due to their extensive knowledge of the illness. They generally apply a strengthening treatment: medicines that prevent the ‘evil’ influences from ‘harming’ the infant any further. This type of medicine is used as a protective measure against the influence of ‘evil spirits’ or influences. Whilst *rigoni* is not considered to be a danger in Zimbabwe, once in Giyani Zimbabwean migrant women come to understand it as an indicator of spiritual danger. They harness Tsonga cultural beliefs and practices in order to sense and off-set any dangers that are specific to their lives in Giyani. This behaviour shows how migrants adopt and adapt not only their behaviours but also their beliefs in these new situations, drawing on the skills, expertise and cultural repertoires of those around them as they learn to make new forms of belonging.

Traditional Modes of Health Services: Mitigating Danger

To investigate how migrant women make use of traditional modes of healthcare to off-set danger, I had an unstructured interview with Namatirai, a Zimbabwean woman. The description below is drawn from her story. Her explanation speaks to the responses I received in this study more widely where migrant women expressed their beliefs in traditional maternal healthcare. Namatirai’s story goes as follows, as recorded in my field notes:

Namatirai, a second-time mother from Zimbabwe, had a child that was bewitched and had a sunken fontanelle in 2016. She checked the entire body of her baby to see if the fontanelle was truly sunken. She checked the skin to see whether it snaps back when pinched. She further checked the eyes and mouth to see if they were dry. Doing this she was confirming whether her baby was dehydrated or not and those are typical symptoms of *nhova* (sunken fontanelle). She confirmed she was taught how to diagnose *nhova* by her grandmother during her first birth. From her previous experience she knew that the doctors at the hospital would say that her baby is dehydrated. She decided not to consult them because, when she previously went to the hospital, they never administered any medication but only said she should give the infant plenty of liquids. They said she would need to offer the baby extra fluids. Yet her grandmother had taught her that ‘kana nhova yemwana ikawira zvinoreva kuti mwana anenge abatwa nemuroyi kana nemunhu ane mushonga’ (a sunken fontanelle potentially is a product of witchcraft or a child could have been got hold by a sorcerer). Immediately Namatirai had to seek help from Mbuya Nyamukuta, a traditional healer and midwife migrant from Zimbabwe performing the same role that she did in Zimbabwe, now in South Africa. [Nyamukuta] always helped her and other migrant women with traditional medicine for reproductive health problems. Among the Shona in Giyani, Mbuya Nyamukuta is an experienced (and as usual) elderly woman responsible for assisting pregnant women before birth, in labour and after giving birth. Namatirai thus went to Mbuya Nyamukuta’s place. Upon arrival Mbuya Nyamukuta administered medication to Namtirai’s baby. She gave him some water mixed with herbs. She took coarse salt and gently rubbed it on his tongue, making sure she did not hurt him. Later on she took the yolk of an egg and applied it to the sunken fontanelle. She told Namatirai to wait and give her child bed rest. That’s how the baby was treated for the sunken fontanelle. Namatirai’s story is not unique in Giyani and in the country of her birth. Many migrant

women confirmed that their infants die as a result of a sunken fontanelle whilst doctors would be emphasising that they should offer extra liquids and milk. In the Shona cosmology, *nhova* is more traditional and spiritual than clinical. Namatirai vouched that babies are given herbs soon after birth to protect them from *nhova* and also to protect them from witches or other people with bad intentions.

Here, *nhova* is interpreted as a physiological sign pointing to spiritual danger. *Nhova* is a common problem affecting migrant women's infants. Since it is associated with the evil spirits, women respond by engaging traditional or spiritual healers. Spiritual healers are believed to exorcise such spirits and to identify the person causing the harm. However, as I have shown, the reliance on traditional healthcare, especially for Zimbabwean women, is not only instructed by their migratory status. It is also based on the Shona culture they grew up in. In Zimbabwe, a *muroora* (daughter-in-law, pl. *varoora*) who gives birth for the first time is sent back to the home of her birth where her *amai nyakutumbura* (biological mother), elderly *tete* (father's sister) or *ambuya* (paternal grandmother) carry the special role of guiding and assisting her in terms of her health. Even *varoora*, unmarried young women who live in town, are given *guchu* (a calabash or bottle with herbs mixed with water to be used as treatment) for smooth delivery and traditional medicine, thus complementing modern medication. People thus adapt the practices they know from earlier repertoires to current contexts, combining what they already know with what they have come to know so as to fashion remedies particular to their new contexts.

In further discussions, I learnt that migrant women are likely to use traditional modes of medical treatment in order to off-set pregnancy-related risks and dangers. This is because diseases are considered by the Shona culture to have physical, mental, social, spiritual and supernatural causes (Machinga 2011: 2). The treatment sought is thus such that transcends physical symptoms to address social and spiritual aspects too. Despite the existence of biomedical systems and Christian spiritual healing approaches, traditional modes of healthcare appear to be particularly pertinent to migrant women. Some migrant women use traditional health services because of their exclusion from biomedicine due to their migratory status. Others expressed preference for traditional medicine over other modes of healthcare. These

preferences normally result from the form that a woman's networks take, especially when the woman has to rely on her networks to detect danger. From Namatirai's story, it is visible how traditional healthcare can lead to positive outcomes, including a decreased need for biomedical and technological interventions and pain medication. Some migrants thus see no harm in using all available modes of healthcare.

The role of traditional maternal healthcare is also demonstrated in an interview I conducted with a 40-year-old Zimbabwean woman named Mbuya Nyamukuta, a key informant in my project. Nyamukuta is a Shona word which means 'midwife'. Mbuya Nyamukuta helps many Zimbabwean migrant women and some locals with maternal health problems. Within the Zimbabwean community in Giyani, she is believed to be experienced and knowledgeable in reproductive health.

Mbuya Nyamukuta does her business in a big room which she called the 'delivery room'. Drawing on Shona cosmology, she does not allow men inside this room as this space is taboo for them. The room is regarded as sacred and only women can access it. Mbuya Nyamukuta explained that childbirth among the Shona is predominately a woman's business and is usually carried out at home (though in present times also in hospitals), while the husband should not be in the vicinity at the time of labour. She explained that childbirth is considered a social event that can create a strong bond among the female participants, friends and relatives attending. Female friends and relatives come into the home to care for the mother, help with household chores, and provide guidance and assurance to the mother. In this space, all sorts of female issues are discussed and advice exchanged for how to take care of a woman's body.

Nyamukuta said that, despite the proximity of modern health facilities, indigenous knowledge and practises are still pertinent in maternal health. She herself uses various seeds, roots, leaves and stems in medicinal preparations with which to treat reproductive health problems, deal with issues that arise during pregnancy and the postpartum period, and care for the new born babies. She explained that she gets her medicines from the forests in the Kruger National Park (see Figure 4.1), though sometimes she also buys them from local vendors.

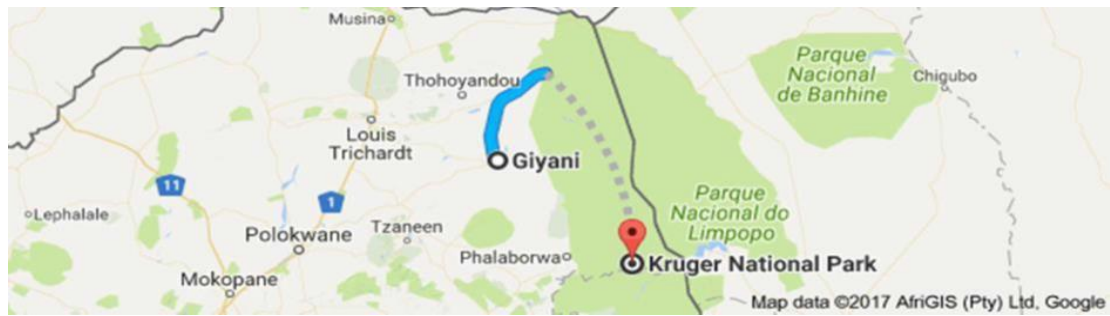


Figure 4.1: Map of Giyani in relation to the Kruger National Park. Source: AfriGIS 2017

Mbuya Nyamukuta told me that many migrant women use traditional healthcare during pregnancy and the post-delivery period. She explained the restrictions that are given to pregnant women in order to keep them healthy before during and after the birth. Thus, certain taboos are placed against ingesting certain foods during pregnancy and the post-partum period. These restrictions apply to all Zimbabwean migrant women, regardless of income, status or access to modern health services. For example, women may not eat eggs during pregnancy because it is believed that it will cause the child to be temporarily or permanently bald-headed. Mbuya Nyamukuta thus advises pregnant women on the special type of foods that *muzvere* (new mothers) should eat, such as salted groundnuts and pumpkin seeds. These are believed to make a women retain a lot of fluids that should replace the blood lost during the birth and to improve the breastfeeding process. Mbuya Nyamukuta confirmed that migrant women rely on her traditional health service. It is also cheaper compared to private medical care.

Mbuya Nyamukuta recounted that shortly after birth the newborn is wiped clean with a soft cloth. The child may not go outside of the mother's home until the *rukuvhute* (umbilical cord) has dried and fallen off (approximately one to two weeks after birth). As people say, 'mwana haabude mumba kusvika rukuvhute rwadonha' (a child is not allowed out of its mother's house until the umbilical cord has dried and fallen). Once this has taken place, the child can be given its first haircut. Mbuya Nyamukuta explained that the first locks of hair, together with the *rukuvhute*, are sacred: they are thrown away or hidden where they cannot be accessed by humans or animals. Some may even keep the locks and *rukuvhute* in order to take them back to their natal homes in Zimbabwe. This is a measure to prevent *varoyi* (witches) from *ikuroya* (also *kushinha*, bewitching) the child.

During our conversation, Mbuya Nyamukuta framed *nhova* as a disease in which diarrhoea is one of the symptoms. She reported that this could mean that the child had been exposed to spiritual danger or impurities, a pollution that can take place especially when a child gets into contact with a witch or a potentially dangerous person:

Kana mwana aroyiwa kana kubatwa nemunhu ane mushonga Nhova inowira. Nyoka inodzika nomuviri, zvichireva kuti inenge yaona kuti pane zvisina kumira zvakana (when a child is bewitched or got hold of by an evil sorcerer, the fontanelle sinks. *Nyoka* goes down the body to give the signal that something is wrong).

This is how danger is detected and suggests to the migrant woman that she needed to call on traditional healthcare. Nyamakuta advised that a newborn baby should be traditionally protected against *nhova* within the first three months of life. In my presence, I saw her helping five Zimbabwean women. Some paid her and others did not. However, in Shona culture, Mbuya Nyamukuta should ideally be given a token of appreciation.

Some Zimbabwean women confirmed that they received help from Mbuya Nyamukuta. During my conversation with migrant women at a place called Xakharawisa in Section F, several of them reported that they consulted traditional healers, herbalists or traditional caregivers. Some reported making use of prophets in Pentecostal churches to detect and treat spiritual danger. For example, the Zimbabwean migrant women confirmed *rigoni* as an indicator of spiritual danger. They revealed that usually it is caused by an evil sorcerer. To avert such spiritual threats, most of them confirmed drawing on Mbuya Nyamukuta's services. They said that her fees are economically viable and that she is easily and quickly accessible.

Traditional healers not only diagnose the symptoms a patient is experiencing, the migrant women explained, but explore what unfolds in the spiritual world and investigate how they can reverse the situation. In Shona, there is a proverb which says 'Pane chariuraya zizi harife nemhepo' (Something has killed the owl; it cannot just be the wind). This means that, besides visible signs and symptoms of illness, there is always an underlying and unpredicted cause. In the eyes of the migrant

women, it is this underlying and unforeseen cause that calls for an exploration of the spiritual situations, so that the source of the suffering can be understood.

The women confirmed using informal information and their networks. They also confirmed seeking Mbuya Nyamukuta's services for the treatment of their babies. In Tsonga culture, a child should be protected against *rigoni*. The Zimbabwean migrant women with whom I worked have embodied this belief. The protection is given by applying *nyora* (small incisions made with a razor blade) around the back of the neck. Alternatively, the child may be strengthened through the administering of certain medicines that protect against evil influences. The medicine is a protective measure against the influence of evil sorcerers. In the instance of *rigoni*, people do not seek biomedical care because they believe that it is caused by witchcraft and evil sorcerers. They normally seek care from traditional healers. These cultural beliefs and practices influence the decision that migrant women take when their children are ill (Kriel and Hartman 1991: 31).

Christian Spiritual and Physical Healing as a Way of Off-setting Health Threats

The study discovered that churches are very crucial in providing solidarity and reciprocity. Not only do these churches offer solidarity, intermingling and reciprocity, but they are instrumental in the face of spiritual danger. They enrich the potential of reducing vulnerability among Zimbabwean migrant women by offering spiritual healing. As I have pointed out above, there has been significant growth in Pentecostal churches in Giyani. These churches attract large numbers of migrant women and children because they offer free spiritual healing. The attraction of Pentecostal churches to migrant women in Giyani is not only common here but also a significant feature among Shona people in Zimbabwe. Tatira (2014: 113) describes this appeal as follows:

Some Shona people are only Christians on Sundays whilst throughout the week they may patronise the traditional healers. The drifting of African members from the mainline churches to the Pentecostal churches is partly explained by fear of witches of such members. The Pentecostal churches become convenient as they claim to sniff out witches and exorcise witchcraft spirits from its

members.

This explains that spiritual evil forces are considered a reality among the Shona. This also informs how migrant women make and shape their everyday choices regarding health resilience. The same women who make use of Mbuya Nyamukuta's services confirmed also making use of church-provided services because they are free and easily accessible.

To find out more about how Christian spiritual healing works among Zimbabwean migrant women, I raised the question during a focus group discussion with ten women. I conducted the discussion one Sunday after the church service at the Conquerors Ministries. The majority of the women confirmed receiving help from churches such as the Conquerors Ministries and the Saints Ministries in Giyani. They reported that churches offer free spiritual and physical healing regardless of one's migratory status. Healing of such kind will be of benefit to those with physical health problems, emotional issues or spiritual problems. On a website providing explanations of Pentecostal theology, spiritual healing is defined as 'the supernatural manifestation of the Spirit of God that miraculously brings healing and deliverance from disease or illness' (Got Questions 2018). Migrant women believed that the power of God destroys the work of *mweya yetsvina* in the human body which is synonymous with healings that were performed by Jesus Christ and the disciples in the Bible. The women expressed that spiritual and physical healing offered in the churches was twofold: while some people who are treated experience immediate and significant changes in their condition, for others, change may take months or even years.

Migrant women described the spiritual healing they receive in church as crucial in their lives as well as critical in off-setting spiritual danger. They explained that spiritual healing works through gestures such as the laying on of hands and through prayers. These are Christian practises that stimulate divine intervention to cause physical or spiritual healing. Migrant women who believe in the practices confirmed that the process of healing of a disease or illness can be by religious faith through prayer or other religious rituals. During the conversation, migrant women reported that many diseases that attack women (both pregnant and non-pregnant) and children are associated with *mweya yetsvina*. The majority confirmed concurrently

using Christian spiritual healing and the services of traditional healers.

Tatira (2014) has observed a similar understanding of illness among the Karanga people (a Shona tribe) in Zimbabwe for whom sickness is something natural. It ceases to be natural, however, when it threatens life or when it lingers for too long without healing. As I observed, this also drives many Zimbabwean women in Giyani to look for Christian spiritual healing in order to build resilience against illness. Many confirmed that they are living testimonies of miracles and recuperation from deathbeds through prayer and fasting. They confirmed receiving spiritual healing which helps them negotiate physical and spiritual danger.

Zimbabwean migrant women explained that the Pentecostal churches in Giyani offer their healing practises to all, regardless of race, nationality or citizenship. For example, a young pregnant migrant woman by the name of Tatenda confirmed that she had been healed by prayer. She was suffering from vaginal discharge during her pregnancy but was instantly healed after the pastors laid their hands on her and prayed for her. She believed the illness was the work of evil spirits.

The spiritual healing offered by the churches allows Zimbabwean migrants to take responsibility of their own well-being and health. These modalities contain a great potential for spiritual, emotional and physical healing. The women explained that, according to the churches, their spiritual nature is the greatest good of human existence. They said that the healing heals their spiritual growth. Through healing, they said, they grow in wisdom and spirit. And it is in the spirit that they are able to embrace healing and well-being. One woman put forward that her five-month-old baby was instantly healed of an illness which looked like sunken fontanelle that was affecting the infant from when it was three months old. Her child was suffering great pain and the fontanelle looked sunken but neither biomedical nor traditional treatment had managed to cure it. She then put her faith in action and went to church to receive the miraculous healing of her baby girl. In a few minutes, her daughter was healed: she could see life in the eyes of her daughter and the child no longer experienced pain. Even the fontanelle was restored back to its proper form. The baby could now eat and cry in the normal way the mother was used to. The migrant women thus emphasised that the church has become a safety net for them which they embrace to negotiate and off-set spiritual, emotional and physical health dangers.

These examples for healing give some insight into the situation in Giyani. Churches are enriching migrants' potential of coping and subverting spiritual health risks, shocks and stresses to which an individual or household is subject. The study reveals migrant women's vulnerability when they do not have access to biomedical defences or modalities of healthcare to cope with health hazards. The churches offer healthcare options, assets and risk-reducing activities that help to them reduce vulnerability.

As already discussed above, churches enable the intermingling of South African and Zimbabwean women. The church thus is a not only a space for worship but also one in which transnational and local networks are created and maintained on which migrants draw for social and spiritual capital based on their shared Christian identity and habitus (Nyamnjoh 2017). Church members are likely to accommodate each other despite differences in nationality. Hay (2014) argues that charismatic worship in Pentecostal churches facilitates a sense of openness and familiarity. These are expressed in physical interactions and bodily practises such as hugging that can inspire free movement and freedom. My observations confirm that migrants do not benefit from spiritual help only when they attend church. They also gain a platform to create convivial relations that they can further transform as capital that allows them opportunities to access biomedical health services. Church activities and rituals also encourage undifferentiating bridging and bonding.

Such flexibility facilitated by churches opens opportunities for migrants to make networks and relationships that allow them not only to belong to the church but to many places at once. The study reveals that migrants are also able to negotiate the process of accessing healthcare when they belong to many places including having relations with healthcare workers who are members of the same church. The church then offers a space and opportunities for mutual construction of conversations across various divides, inequalities and orders. In this case, the church becomes the bridge between migrant women and healthcare workers. As I have shown, it inspires a way of facilitating and consolidating healthcare and well-being for them regardless of their differences in status.

Conclusion

Zimbabwean women use both traditional modes of healing and spiritual faith

healing, often simultaneously, as strategies to cope with health danger. Their choice of mode of healthcare is influenced by the way they detect, diagnose and define a disease, lack of health or illness. I observed that indigenous knowledge helps migrant women in making decisions and adapting to health risks, shocks and stresses. They interpreted some of the health threats as having spiritual causes whilst others were seen to be physical, and some to be both. The migrant women used traditional medicine to treat diseases and illnesses like *mweya yetsvina*, *nhova* and *rigoni*. In cases where they felt that traditional healthcare was inefficient, they co-opted Christian spiritual healing. In getting by and surviving among migrant women, the convergence of traditional medicine, spiritual healers and biomedicine can be instrumental in off-setting health-related dangers broadly understood.

Chapter 5. The Role of Local Institutions in Building Resilience and Adaptive Capacity amongst Migrant Women

Introduction

In Giyani, there are a number of active public, private and civic institutions helping migrant women in building adaptive capacities and resilience against health challenges. These local institutions have different roles and capacities in reducing vulnerability amongst migrant women. This study evaluates the relationship between health-related vulnerabilities and initiatives brought in by local institutions to build the adaptive capacities of vulnerable migrant women. Local institutions are regarded as principal leverage points and safety nets for vulnerable migrant women (Uphoff 1997). They are vital in channelling information, technology, financial and policy intervention which are instrumental assets in building resilience against health risks. As noted by the TAC (2014), local institutions are vital in fostering access to healthcare and treatment. As my research indicates, there are a number of private, public and civic institutions operating in Giyani which may be classified as formal and informal institutions. Both types have had successes and have encountered challenges in implementing initiatives and interventions.

First, private institutions include NGOs, CBOs and voluntary associations. These are important in financing adaptation interventions, organising awareness campaigns, and offering biomedical and non-biomedical services to migrant women and families. IOM (2014) suggests that ‘the role of NGOs is to ensure that the voices of vulnerable migrant women are included in research and programme design.’ Local NGOs, such as the TAC, Management Sciences for Health (MSH) and the IOM, coordinate and unite at a local level with international funders like the United States Agency for International Development (USAID) to strengthen the adaptive capacities of vulnerable migrant women.

Second, public institutions include government departments like the Mopani District DOH, the Limpopo Province DOH, and the Giyani Community Service

Department which works directly with the communities mobilising resources, information dissemination and decision making. Together with ministries at higher levels, these have the mandate to formulate laws and policies that shape the participation of migrants and their access to resources and opportunities (Agrawal 2008; Mafongoya forthcoming). As this study has already observed, public institutions play a less significant role in reducing women's vulnerabilities due to the hostility of some of its personnel toward migrants.

Third, civic institutions include both formal and informal organisations at various social levels. In most cases, they are informal. They include but are not limited to village development committees, women's church groups, small-scale credit schemes, co-operatives and youth clubs. Uphoff (1997) classifies civic institutions into both formal and informal groups. Among the people I worked with, most institutions that support them are informal. They include community burial societies, cooperatives, asset exchange clubs, money rotating clubs and church groups.

I explore each of these three sets of institutions in turn below, examining how practical survival and resilience amongst migrant women is shaped by compatibility and significance of local institutions and interventions. My research demonstrates that most informal institutions are coping avenues, fostering adaptation of vulnerable Zimbabwean migrant women. Migrant women turn more frequently to informal institutions than to state institutions. This is because these informal structures facilitate social support networks and sharing, grant access to health-related information, and enable interaction, thus augmenting migrants' adaptive process. Moreover, some formal institutions like NGOs play a crucial role in helping migrants adapt to health threats. Local institutions are therefore conduits through which support for adaptation and resilience is delivered. Central to the various sizes and responsibilities of local institutions is horizontal and vertical collaboration between them. Mafongoya (forthcoming) points out that 'co-operation between formal and informal local institutions determine the direction and speed of adaption to threatening disasters.' Success stories of collectivism determined by local institutions' possession of knowledge, financial resources, information, technology and excellent management skills are well documented in my study. Adaptation to health threats is enhanced by the local institutions' in-depth knowledge and

experience in the management of finances, knowledge and related resources.

Private Institutions as Coping Avenues Fostering Resilience

NGOs as Intermediaries

During a conversation, a TAC official narrated a story about a Zimbabwean woman by the name of Theresa who was turned away from a hospital and neglected for six hours because of her migratory status. Theresa had fled Zimbabwe in 2013, escaping the economic downturn and political chaos. Together with her husband and their son, she went to Tzaneen in search of improved life chances. In 2016, she fell pregnant with her second child. She received antenatal services at the local clinics in Nkowankowa, in the greater Tzaneen area. One afternoon, as Theresa was in town shopping, she went into labour. She was rushed to Letaba Hospital to receive treatment. Once arrived, healthcare practitioners claimed that they could not assist her because she lacked the papers to verify her right to be in South Africa. They also said she might need a caesarean section which requires a lot of documentation and signing of protocols with witnesses that have documents. She was denied entrance to the facility and sat waiting outside the hospital's entrance for hours. When her husband arrived two hours later, the hospital authorities would still not help.

Once the couple realised they would not receive treatment, Theresa's husband called a TAC activist to come and liaise with the hospital staff. Theresa spent another hour in pain waiting for the activist's arrival. By the time the activist arrived, she had been in labour for four hours. When the TAC activist tried to make his way into the hospital with Theresa, he was blocked by the security personnel. In spite of all his frantic efforts to explain that migrants have health rights, his efforts were in vain. In effect, as I have shown in earlier chapters, regardless of South Africa's progressive healthcare policies and immigrant rights regime, migrant women's lack of proper documentation (residence permits and work permits) precludes them in practice from accessing state-provided reproductive healthcare. The TAC activist had no option but to call the TAC's provincial manager who then contacted the head office of the Mopani District DOH to explain Theresa's situation. Eventually, after a further hour of a bureaucratic communication process, the Mopani District DOH called the authorities at Letaba Hospital and instructed them to

assist Theresa. Finally, after 6 hours of labour, Theresa was admitted to the hospital, shortly after which she gave birth. She was blessed with a baby boy.

Theresa's experience of struggling to get into a hospital to give birth was well known among TAC officials and my interlocutors. After the TAC official had told me Theresa's story, I was present when the organisation engaged with the Mopani District DOH to discuss migrants' experiences when accessing health services. Many Zimbabwean migrant women have numerous experiences of discriminatory treatment at government health facilities. They narrated the various struggles they thus encountered. As I have already demonstrated in Chapters 1 and 2, it is very hard if not impossible to access treatment in government health facilities if a migrant does not produce documentation. As Theresa's experiences indicate, interventions by the TAC and its partners are a significant resource for migrants in addressing these challenges. The TAC regulates health rights and coordinates with decision-makers at higher levels to help migrants access state-provided healthcare.

The majority of research participants in this project confirmed that public institutions such as Letaba Hospital and Nkhensani Hospital in Giyani are not fully transparent and inclusive. They segregate migrants based on their documentation status. By contrast, private institutions like NGOs are active and show transparency and inclusiveness. They are playing an instrumental role in bridging the gap between government health facilities and migrant women. My research shows that NGOs are critical in mediating multi-stakeholder dialogues and collective processes for managing healthcare exclusion of migrant women. As Theresa's experiences have indicated, TAC is mediating a dialogue between the government entities and migrants. It also has proposed various projects to help vulnerable migrant communities. NGOs such as TAC, Anova and IOM are intermediaries between 'private' institutions, donor agencies and government entities in problem cases where migrant women cannot access healthcare.

I interviewed Moses Makhomisani, the TAC's provincial manager, who confirmed that TAC projects have contributed substantially to strengthening relationships and building the ability to implement programmes with its partner organisations, like IOM, MSH and Anova. He said that most of their programmes have succeeded and have significantly contributed to HIV prevention and related health challenges in migrant communities. He described how their interventions

simultaneously address spaces of vulnerability, for example, the spaces where migrants live, work and pass through, and the vulnerable migrants themselves. Makhomisani acknowledged that health vulnerability is not only a result of individual situations but due to the coming together of a range of factors specific to unique conditions of location, including relationships among migrants and locals.

During our discussion, Makhomisani confirmed the involvement of a DOH mobile healthcare unit at all key events organised by the TAC, such as community *imbizos*. This has proved to be relevant in addressing the health access challenges among migrant women. He said that the accessibility of the mobile healthcare units has enabled migrants to attend clinics closer to their homes without risks. Apart from that, the TAC partners with international funder like USAID. Together with efforts from Anova, IOM and other partner organisations, the TAC has managed to reach a significant number of migrant women and children. Makhomisani revealed that, for 2013 and 2014, the TAC partnered with MSH to run a USAID-funded project on HIV prevention for migrants in Limpopo. The project reached a significant number of migrants. Through the project, the TAC also managed to equip migrants with information and facilitated their access to medical care. Makhomisani confirmed facilitating multi-stakeholder dialogue and collaborative processes for mitigating health challenges encountered by migrants. His explanations indicate that NGO interventions aim to facilitate a multi-party and holistic approach in order to achieve comprehensive and sustainable long term solutions.

The TAC banner (see Figure 5.1), used during community dialogues, screening activities and other related health advocacy work, makes clear the links between the organisation and its partners, the MSH and USAID. The HIV intervention was profound as it employed migrant women as counsellors. Female team leaders used their own networks and those of friends to reach out to migrants who would otherwise prefer to remain less visible, as described in Chapter 1. The workshops were designed to teach team leaders about relations between migration and HIV and to impart knowledge about migrants' health and rights. In this way the recruited migrants were made a critical part of the HIV Prevention and Treatment Literacy (PTL) campaign. Migrants confirmed the project bringing their voice afore.



Figure 5.1: TAC campaign poster for migrants' access to healthcare. Source: TAC 2014

I spoke with some people who had been beneficiaries of the TAC project. Tsitsi, for example, described the project in this way:

TAC project has helped us [migrants] so much. It brought mobile clinics to our communities and we are able to access treatment within our locations without having to walk to hospital. Now that there is a mobile clinic it has become better. We have avoided the struggle of being stereotyped and verbally attacked in most local hospitals, especially Nkhensani hospital. I remember being told that Zimbabweans smell badly ...

The claim that the TAC brought the clinics is linked to the fact that the DOH clinics are present at TAC activities (see Table 5.1). Tsitsi's explanations show that it is not only those institutions that are flawed in terms of granting health access, but that individuals are exclusionary and discriminatory. Findings have confirmed that in intervention and adaptation conditions, private institutions such as the TAC are more able to manage local initiatives than government public health facilities. The results that they achieve have confirmed that they are flexible in their structures. This becomes the currency that augments harmony between migrant and healthcare at local level. Beneficiaries of TAC projects have indicated that these private institutions are vital in linking them to available resources and interventions. They are key elements to anchor sustainable adaptation to health threats.

#	Indicator	Code	Disaggregated totals (cumulative)				Quarterly Totals				Cumulative Total
			M 1 0- 1 4	M 15 +	F 1 0- 1 4	F 15 +	Q1	Q2	Q3	Q4	
1	Number of targeted populations reached with individual and/ or small group level preventative interventions that are based on evidence and/ or meet the minimum standards required. (Disaggregated by sex and age (10-14, 15+). (PEPFAR P8.1.D)	BLC28 PEPFAR P8.1.D		18 07		26 58	0	479	235 7	15 93	2560 locals 1869 Migrants
2	Number of MARP reached with individual and/or small group level interventions (<25 people) that are based on evidence and/or meet the minimum standards required. (Disaggregated by gender, age, MARP type and type of intervention). (PEPFAR P8.3.D)	BLC30 PEPFAR P8.3.D		51 9		75 1	35	85	654	52 6	locals: 700 migrants: 600
3	Number of individuals from target audience who participated in community-wide event. (P8.5.D)	BLC32 PEPFAR P8.5.D	Screening Dialogue				07	310	170 4	73 5	1749 locals 1000 migrants
4	Number of condoms distributed	BLC31 HVOP2					0	137 90	232 00	36 83 2	73822
5	Number of individuals who received Testing and Counselling (T&C) services for HIV and received their test results. Disaggregated by sex and age (<15 years, 15+ years).	BLC33 PEPFAR P11.1.D	M < 1 5	M 15 +	F <1 5	F 15 +	0	0	0	0	
6	Number of eligible adults and children provided with a minimum of one care service. Disaggregated by gender and age- children <18 years and adults +18 years.	BLC40 PEPFAR C1.1.D	M < 1 8	M 18 +	F <1 8	F 18 +	0	253	0	32 9	2500 migrants

Table 5.1: The number of people reached by the TAC. Source: TAC Report (2014)

Among the NGOs that help migrants with their health needs is IOM. One IOM official confirmed that the organisation collaborates with strategic local partners such as the TAC in order to build its capacity for improved service delivery

for migrants. Unlike the TAC, IOM assists with both biomedical and non-biomedical services, especially as people cross into South Africa. Its aim is to address multifaceted health risks stretching from individuals, households and migrant communities. IOM reinforces its relationship with migrants, health-related vulnerabilities and the adaptation initiatives it brings in order to build the adaptive capacity of vulnerable migrant women and families.

During my research, I met Maria, a 38-year-old woman who had received assistance from the IOM when she entered South Africa. She explained her interaction with IOM as follows:

I was helped by IOM when I was sick, while travelling to South Africa. It was my first time to cross the border and I hardly knew anyone. I saw a banner in Musina town, written International Organisation for Migration, and approached the offices for help. I received treatment and health information. During that time I was receiving treatment, I saw approximately 10 migrants, both men and women, also coming to receive treatment. IOM is doing a great job of helping migrants.

In the stories that Zimbabwean migrant women told me of their difficulties in accessing health services in South Africa, it became clear that NGOs act as conduits for delivering healthcare and for mediating between migrants and the state.

Informal Institutions: Cohesion and Resilience

While private institutions such as NGOs were significant in assisting migrants to access healthcare and in mediating between state and individuals, I learned that the most significant spaces for social support lay in people's everyday associations. I have already described the ways that marriage and other relationships, lubricated by a convivial attitude, are important. I turn now to address another set of relations, those founded on saving and exchange. These structures with economic foundations were found to be important means both for creating and maintaining networks and for enabling support.

Rotating Savings and Credit Associations and Asset Exchange Arrangements

Rotating Savings and Credit Associations (ROSCAs) (see Mushuku and Mayisa 2014) are a popular form of informal finance. A small number of individuals, typically between six and forty, form a group and select a leader who periodically collects a given amount from each member (Mushuku and Mayisa 2014). The money or the goods are then distributed in rotation to each group member at certain intervals. In Giyani, for example, money rotating clubs for Zimbabwean migrant women are built on the basis of similar citizenship or friendly economic traits.¹ They are also based on cohesion, solidarity or reciprocity within the migrant community. As Geertz (1963, cited in Mushuku and Masiya 2014: 120) puts it, ‘money rotating schemes included groups of people who already have a relationship of some sort such as employment in the same organisation, same ethnic background, friendship [locally known as *hushamwari*, as described in Chapter 3], neighbourhood or business ties.’ These groups are key elements in household livelihood strategies and in accessing scarce resources including financial capital and, more importantly, healthcare services.

In Dzumeri, for example, there is a popular migrant money rotating club called Fushai (a Shona word which means ‘preserve for future use’). This informal savings group ensures a level of food and health security, and is a safety net for vulnerable migrant women. I met members of the association, most but not all of whom were migrant women from Zimbabwe. The majority of them said that they use Fushai as a means to save money and to ensure that they do not have to give it to their male counterparts. As Ross (1990: 7) puts it, ‘this is regarded as a womanist economic system.’ Fushai acts as a means through which money can be classified as different from ordinary household finances. The women said that most of the times their male counterparts know little about the amounts they invest. They would make these arrangements among the women, without their husbands attending. They said that Fushai helps individuals with money when they face disease, illness or another

¹ Friendly economic traits refer to cordial qualities or characteristics of mutual production, development, and management of material wealth, between and among groups, households, or business enterprise.

form of adversity. Its members extend emotional support towards each other but also give material goods, especially to migrant women and children before, during or after a time of crisis. Intimate knowledge on members, seasonal requirements, individual and household capacities to repay, as well as social pressures for both lenders and borrowers to retain their good standing in the community shape the availability of funds and support. These informal savings groups allow migrants to circumvent the difficulties they face in establishing formal bank accounts, where they are required to provide official documentation such as work or residence permits and a proof of residence to open an account. Fushai, which meets every two weeks, operates as a collective effort that helps each woman spread the shocks and stresses that result from being excluded from a variety of social services as well as meet her everyday needs. It also provides prospects for participants to network and support each other in times of economic and health-related crisis.

Fushai members are able to obtain interest-free loans from the group, doing away with the transaction costs and risks associated with accounts at formal institutions. Even the money they contribute every month is not fixed: it varies according to the amount they were able to acquire during that month. One of the women explained Fushai's benefits in the following way:

Money lending can happen out of our own homes. We can combine finance with other business such as healthcare access. The services provided are outside the review and control of the monetary authorities. Fushai provides a space to network with people in positions of power such as nurses. This enables us to have access [to] health services.

These sentiments largely represent the opinion held more widely among migrant women. Members are able to transform relationships that originate from Fushai into linking capital that they can use to off-set the uncertainties of everyday life and the shocks it contains. Strong traditions of mutual assistance and reciprocity mean individuals who need funds can call on other members or the group leader for help. Acceptance of such help obligates the borrower to reciprocate by providing non-financial services or by supplying funds in turn when the lender needs to borrow. The borrowing is also strategic. Members confirmed that lending money to

healthcare workers opens up networks and opportunities for easy access to health services in return. Those to whom I spoke confirmed that when nurses borrow money, they provide non-financial health services to their fellow Fushai members, thus the migrant women, in return for the money favour and in order to maintain relations. However they will also repay the money they borrowed. Non-members are also allowed to borrow from Fushai but have to pay back the money with a 30% interest.

Fushai plays an essential role in the livelihoods of migrant women in Giyani. This includes but is not limited to healthcare payments, security functions, asset accumulation, and starting and expanding a new business. Twelve members of Fushai revealed that they have accumulated assets by participating in Fushai. When it is their turn to receive the sum collected, they buy electrical gadgets, solar panels or machinery to send back to Zimbabwe. Fushai is important to them because it allows them to invest in assets by having access to an accumulated amount of money. In this manner, members are also able to pay for private healthcare. Most of Fushai's members said that they joined because they believed that they could use the money invested in times of adversity, such as bankruptcy, death or illness. One member explained the help she got from Fushai in this way:

When my son got sick, Fushai helped me to pay the hospital bills at Kremetart Health Centre. I used the Fushai money and my husband was very pleased at how I managed to pay the bills and buy medication without him paying anything. My husband was broke, he didn't have money. Zvakange zvakadzvanya [the situation was tough] and he was not working, but because of Fushai we sailed through.

Accumulating assets and using the money as security or insurance against health shocks is a way that improves the health resilience and livelihoods of migrant women. Through attaining social capital, they are able to transform it to linking capital which opens up other opportunities that can be used to build resilience against health risks.

The strength of a ROSCA is often linked to the level of social capital and community cohesion it is able to command. In contrast, formal or non-local

interventions often bypass disadvantaged and vulnerable migrants because their needs and capacities are invisible to outsiders, largely because there are no avenues of mutual trust (see Bähre 2007). In ROSCAs, new members are introduced to the group by existing members, so that one member vouches for the trustworthiness of another. That puts huge social pressure on members to conform. Trust is thus a critical component in weathering everyday life and activating social networks through these informal credit associations.

Migrant Burial Societies as Coping Avenues

Migrant burial societies provide mutual help and assistance to members and their families in the event of death or illness. They are an established feature of life beyond South Africa's borders (see Hall 1987). Migrants that have no access to public healthcare rely on their own, through platforms like burial societies. Hall (1987: 49) states that burial societies are 'seen to offer a measure of financial security in the event of bereavement and also cater for some of the social needs of the members.' As I demonstrate in my research, burial societies are a form of social capital embraced by migrant women as coping mechanisms to adapt to life and health threats.

I met with women who were members of burial societies and hosted a discussion about how such groups work. The participants expressed that, in the event that the man only is entitled to membership of a burial society, the member's wife and children are covered in terms of the normal benefits provided by the society. Yet a wife is not entitled to her own membership if her husband is still alive and an active participant. Unlike the savings groups described above, then, men represent their households as main members in burial associations. Monthly payments or subscriptions to the society are not fixed but correspond with the number of beneficiaries involved. For example, members of Harusiyi Burial Society pay an amount of R100 for each adult older than 18 years and R50 for children below 18 as monthly subscription fees. The participants revealed that the main member is responsible for the payment. If a member dies, the burial society pays for the funeral expenses and also gives financial assistance to the family of the deceased. Harusiyi, a Shona name which means 'Death does not discriminate', offers additional benefits such as payment of hospital bills in the case of sickness, the provision of food to a

deceased's family members, the or payment of the costs to repatriate the corpse to Zimbabwe. The majority of migrant women confirmed receiving emotional support and comfort from Harusiya in the event of sickness or death in their families. One participant had this to say:

When my husband died I had no one to turn to except my friends who are members of Harusiya. They saw me through the grieving moment of the untimely death of my husband. They helped with household chores such as cleaning the house, cooking and even making sure my children have washed and got food. They were right here with me singing throughout the night. They even accompanied me to Zimbabwe for the burial.

This narration reflects the group solidarity among migrant women created through a burial society. In addition to receiving financial support, Harusiya members reported that they received assistance from other members with practical tasks, such as assistance with cleaning, doing chores and assisting with childcare. These actions enable the bereaved to grieve in the community of others. I observed that Harusiya is a dependable form of social capital that allows social networks that are very crucial in times of need.

The information above shows how women are able to negotiate some sets of relations on their own, as women (for instance, through savings groups) but in other instances must be represented by a man. There are interesting and complex gender dynamics at play here that link with the roles people take on in households and over lifecycles. In Shona culture, matters of life and death usually are men's responsibility, thus explaining their roles as main members in burial societies.

Traditional Institutions as State Institutions Fostering Resilience

Traditional institutions are part of the local institutions that are crucial for migrants to adjust to changes in economic and health conditions. Whilst traditional institutions are formally regarded as state institutions, I found local authorities like the Homu Traditional Council and the Dzumeri Traditional Council to be flexible and represent the interests of all members of their communities. For example, both of these councils are loosening traditional property rights in order to allow migrants to gain

access to resources. They are helping numerous migrants apply for permanent residence permits. They extend this help to migrants that have lived in Homu and Dzumeri for more than five years.

Daniel Mathebula, an official at the Homu Traditional Council explained to me that traditional councils are intermediaries between the state and migrants. They mediate the process of issuing permanent residence permits or identity documents for migrants who qualify. Mathebula mentioned that some are even granted the bar-coded green identity book, though this would specify that they are not born in South Africa. He told me that local councils are facilitating the process for those migrants who are loyal and do not commit crimes. This means that all migrants who observe societal laws, respect cultural practices, attend funerals and live together with others in harmony are able to get ‘favours’ from the traditional council. They have to prove first that they are part of the community by showing respect for its norms and participating in its important activities. (I have described this on a more detail in Chapter 3). The council writes a letter and stamps it for the migrant to submit to Home Affairs, or an official from the traditional council accompanies migrants to the Home Affairs offices to negotiate the process of issuing documentation that then eases people’s way into the health and other services that they are already entitled to. This indicates that traditional local institutions have a far more tolerant and enabling policy environment that is beneficial to migrant women than other state institutions.

Not only do these traditional institutions link migrants with papers, they also offer health advocacy for migrants. For example, Homu Traditional Council was involved with the TAC’s 2013–2014 HIV prevention projects for migrants. On 7 November 2013, a project introduction took place at the Homu Traditional Council meeting at Homu 14A in Giyani. A delegation from the TAC was granted permission by the council to ‘make 20 minutes’ (speak briefly) on the subject. Amukelani Maluleke, then the provincial manager, and Makhomisani, the present manager, honoured the invitation. Maluleke gave a detailed presentation of the proposed project to the council. After the presentation the chief asked:

Why only proposed areas and why should we care about foreign nationals and if there are any plans in place to extend to other areas of Giyani?

In response Maluleke said:

Migrants have health rights and it is the duty of the community to help them. Their problems also affect the community hence there is need to extend healthcare to migrants.

The council then took the decision to grant permission for the implementation of the project at the proposed areas. Furthermore, Headman Manyange, widely known as Nduna Manyange, was assigned to work with the project. Manyange and his council took the front row as a sign of approving all project activities. Manyange and his delegation also petitioned the Giyani Health Centre to provide a mobile health unit in Giyani for biomedical care whenever people, including the targeted migrants, were attending TAC events. As we saw earlier, this unit is widely appreciated by migrants. Continuous support from the traditional council noted a dramatic rise in attendance and health access by migrants.

The above indicates that the maintenance of peace and unity with migrants is seen here as a pivotal duty played by a traditional council. They contribute in establishing formal institutional relations between different sectors of society (such as the state and NGOs). They offer assistance based on what we might call evidence of assimilation—the fact that people must adhere to local practices such as funerals and be good citizens in the terms laid out by host communities.

Conclusion

There are a wide range of local institutions operating among Giyani communities. Informal institutions at community level often act for the absent formal institutions. These are safety nets that migrant women possess before, during and after disasters happen, especially when migrant women are neglected by the government. NGOs, traditional institutions and civic informal institution, such as money rotating clubs and burial societies, have shown to be more resilient local institutions. The study reveals that there is great need to understand existing social patterns in order to avoid the pitfalls of undermining present institutions by introducing competing associations. This may result in short term initiatives rather than building migrants' practical adaptation and resilience in the long term. Partnering with local institutions and authorities is pertinent in extending legitimacy, knowledge and sustainability to

interventions. This has facilitated migrants in acquiring documentation which regularises and legitimates their stay. In the long term, this will help build sustainable adaptive capacities, concurrently reducing exposure to health risks, shocks and stresses.

Chapter 6. Conclusion

Revisiting the Model of Suffering and Surviving

I observed that migrant women suffer exclusion from healthcare yet survive using social networking as a means to an end. Suffering is predicated on the perceptions and attitudes of healthcare providers and state institutions, despite migrants having their health rights enshrined in the South African constitution (Crush and Tawodzera 2016). Using Chabal's conceptual framework of suffering and surviving, I have shown that migrant women simultaneously suffer but survive exclusion from health access by using a number of adaptive and innovative strategies. These strategies involve social networking, sensing and knowing health-related danger, and embracing local institutions that build their adaptive capacity.

The study has shown that many Zimbabwean migrant women experience significant struggles in entering South Africa (see also McGregor and Primorac 2010). As I have shown, migrant women are the receiving end of xenophobic attacks and attitudes in South Africa. Prior to Zimbabwe's economic collapse, Zimbabwean migrants were able to move easily to South Africa. The desire for migration has increased as a result of the failure of the Zimbabwean economy (Morreira 2010; Hartnack 2005). However, migrants' mobility is reduced by stringent immigration policies (Mbembe 2017) which force them to come to the border to renew their visas regularly. This means the costs of the survival option of fleeing to South Africa has been raised. However, migrants are exercising agency by circumventing the boundaries of the nation state. They use various ways of crossing into South Africa. Boundaries are both obstacles and opportunities for those who are trying to make a living through migration or trade (Chabal 2009). Borders are not officially open to negotiation so that informal migration arises in order to subvert the stringent laws.

The study has shown that whilst migrant women are running away from economic mayhem in Zimbabwe, they also find themselves exposed to xenophobia and serious health threats once in South Africa. In this case, lack of proper documentation like residence or work permits excludes them from accessing basic health amenities, further worsening their already threatened livelihoods

(Muzondidya 2010). I also equate these threats to the concept of suffering. After tracing migrant women's engagement with public healthcare facilities before, during and after giving birth, I observed that women's access to healthcare is problematic, due to their lack of papers. Despite the fact that migrant healthcare rights are covered in the constitution and a number of international protocols that the country is signatory to, they still face exclusion (Crush and Tawodzera 2014). The constitution's Section 27 states that healthcare services and spaces should be available, economically sustainable and physically accessible to everyone on a non-discriminatory basis. In particular pregnant women and children under the age of six enjoy access to free healthcare, irrespective of migration status (Chekero and Ross 2018). Yet what seems clear 'on paper' becomes considerably more opaque when experienced by those who do not have 'papers'. By denying migrants access to healthcare, healthcare professionals in public institutions compromise migrants' health-seeking behaviour. Their vulnerability to exclusion is high due to the hostility they face by South African health officials who do not observe the constitutional provisions.

When denied access to healthcare, Zimbabwean migrant women embrace various social networks such as marriage and *hushamwari* relationships, drawing on sociality and conviviality as adaptive strategies. Through transnational marriages, migrant women invest in co-reliance to deal with challenges troubling their existence in Giyani. It has been also noted that social networks are one way in which migrants boost healthcare access and increase their expected returns and well-being (Sibanda 2010). The characteristics of the social networks they build up shape the connections that they can co-opt to adapt and facilitate resilience against health threats. Chabal (2009: 137) notes that 'exchange in these networks is overwhelmingly the main source of income for most Africans and in this case for migrant women'. Migrants who earn a living in this way necessarily depend on the bonds of obligation and reciprocity. My findings have confirmed that migrants rely on ROSCAs and burial societies which are typical of bonding capital brought together by links of moral obligation and reciprocity. The research has shown that women try to activate the collective networks to which they belong, and also attempt to invent new ones in the money rotating schemes and burial societies to which they belong. They further create new ones when they lend money to influential figures like nurses to further

open up opportunities of accessing healthcare services.

Whilst Chabal concentrates on the collective and the religious networks in the politics of survival, I draw on his concepts to explain how migrant women have relied on collective efforts or mutualism and religious networks in accessing health services. Churches are not only a powerful vehicle for networking, but are also networks of reciprocity and patronage (Hay 2014). As the findings presented in this study have shown, convivial relations created in churches are essential in accessing healthcare. They have shown positive results despite medical xenophobic tendencies exhibited by healthcare practitioners within the public health facilities. My findings have shown the effectiveness of mutualism and social networks when the same healthcare workers who deny migrant women access to state facilities provide healthcare within the setting of the churches. Though social networking between migrants and the host population may be disputed, the social bonds made through churches, marriages and sociality are inevitably strong (Nyamnjoh 2017).

I observed that Zimbabwean women simultaneously use traditional modes of healing and spiritual healing as strategies to cope with health risks. Their choice of the mode of healthcare is influenced by their migratory status. When they are excluded from accessing public healthcare, they opt for other alternatives such as traditional healers or Christian spiritual healing. In addition, the way they sense and understand health risks also informs their choice of healthcare. The nature and significance of healthcare modality helps them in making decisions and coping with health risks, shocks and stresses. Results have indicated that some of the health threats are spiritual whilst others are physical.

While biomedicine deals with what it considers to be physical/biological ailments or potentials, women take a wider range of agents into account in their quest to secure well-being for themselves, their foetuses and their children. These include attention to physiological signs that may indicate spiritual danger. These affect but are not limited to dysfunctions of pregnancy, delivery complications and health risks in children. Migrants and their hosts may read these as signs of vulnerability to forces beyond the body. As a consequence, they seek to off-set them by making recourse to a range of practices, including visiting traditional healers and using traditional medicines. Migrant women have harnessed Tsonga cultural beliefs and practices as one way of sensing and off-setting dangers specific to their lives in

Giyani. Migrants adapt not only their behaviours but also their beliefs, drawing on the skills, expertise and cultural repertoires of those around them as they learn to make new forms of belonging. Some draw on Christian spiritual ideas about healing and many others combine various approaches. The convergence of traditional medicine, spiritual healers and biomedicine can be instrumental in collective and sustainable off-setting of health-related danger. It is also described by Chabal as the informalisation of the politics of survival. He further describes informalisation as precisely the process whereby the 'modern' and 'traditional' interact in a dynamic of agency that seeks to overcome existing constraints to living a 'decent' life. Agency is applied to opportunities that arise from the combination of available mode of healthcare in a process that subverts the public healthcare system. In both instances, relations of proximity and reciprocity provide the foundations upon which migrants and healthcare providers relate to each other within and across communities.

The study has shown that there is a growing consideration of adaptation to health threats. A wide range of local institutions operate in Giyani communities. Most of them are informal institutions at community level, often acting in place of the absent formal institutions. These are safety nets that migrant women access before, during and after disasters happen, especially when they are neglected by the government (Agrawal 2008). NGOs, traditional institutions and informal civic institution such as money rotating clubs or burial societies are chosen by migrant women to adapt to health threats.

I have shown that the partnering of NGOs, such as the TAC, IOM and Anova, with donors such as USAID is only possible if there is flexibility, the willingness to reform, and a sincere commitment to assist. Partnering with local institutions and authorities like the Homu Traditional Council is pertinent in extending the legitimacy, knowledge and sustainability of the projects instituted by these private agents. This has facilitated migrants acquiring documentation that regularises and legitimates their stay. In turn, this will help build long term sustainable adaptive capacities concurrently with reducing exposure to health risks, shocks and stresses. Migrants should not always be treated as vulnerable victims. I observed that migrant women are not passive but that they possess agency consolidated through social networking that enables them to transform their situation for the better.

Potentials and Shortcomings of the Research

The following recommendations are addressed to government arms dealing with migrant issues, such as the Department of Home Affairs, as well as to town planners and NGOs dealing with migrant health issues.

Despite protective legislation, migrant women still encounter challenges in accessing health services. I suggest that there is need for integrated research and policy intervention to improve productive and reproductive healthcare access for migrants living in South Africa. Such mediation should be sensitive to the ways people and organisations already foster practical survival and resilience amongst migrant women. Interventions should not treat spaces of vulnerability (such as spaces where migrants live, work and pass through) and the vulnerable migrants separately, but should rather address them simultaneously. Not only are institutional relations flawed in terms of granting health access, but individuals are exclusionary and discriminatory. Public health services should be migrant-friendly. The government and advocacy organisations should employ checks and balances on health delivery, especially with issues relating to migrants.

From the research, I observe that there is great need to understand existing social patterns so that the pitfalls can be avoided of undermining present institutions when introducing new, competing associations. Introducing new structures that do not take existing ones into account may result in short term initiatives rather than in building migrants' long term practical adaptations and resilience.

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