Xenophobia and Intergroup Conflict: An Inquiry Through The Concept of Health

A qualitative field study on the perceptions of health among refugees and asylum seekers in Cape Town, South Africa

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Motivated by the ongoing and widespread xenophobia in South Africa, this study explores the experiences of health access and the health sector by refugees and asylum seekers so as to understand intergroup relations, and more specifically the tensions between nationals and non-nationals. In achieving this, an ethnographic fieldwork was conducted in Cape Town, South Africa during Spring 2017; semi-structured interviews with refugees and asylum seekers provide the material for analysis to identify key perceptions on health and xenophobia to shed light on what possible peacebuilding initiatives should address. Key themes uncovered that intergroup violence based on nationality is prevailing in the areas and townships where refugees and asylum seekers live side by side with (black) South Africans. The presence of violence and the fear of risk of violence appear to fuel inter-group resentment and hostility. The lack of social well-being of the refugee became apparent in their frustrations in attaining safety in their everyday life. Moreover, it positions them so that they are unable to improve their own situation and attain health, health access, and health rights. Additionally, it found that a major obstacle to the realisation of health is connected to legal documentation as well as perceived competition for scarce health service. Specifically, it uncovered the perception of assumed hostile attitude (or fear hereof) by nationals among refugees and asylum seekers constitute both visible and invisible access barriers to the public health system and social integration. The application of the instrumental group conflict theory to the ethnographic interview material thus showed that to end what I term ‘norms of protracted social conflict rooted in xenophobia’, refugees and asylum seekers access to and treatment in the health sector is integral for their inclusion into society. It can simultaneously foster relations with the locals and, at the same time, allow for an everyday life wherein the individual can participate in and contribute to the South African society.

Keywords: Instrumental Group Conflict Theory, Cape Town, South Africa, Intergroup Conflict, Refugee, Asylum seeker, Xenophobia, Xenophobic Violence, Health Access, Health Service
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<td>Democratic Republic of Congo</td>
<td>DRC</td>
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<td>Department of Home Affairs (Republic of South Africa)</td>
<td>DHA</td>
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<td>Instrumental Model of Group Competition</td>
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<td>National Health Insurance White Paper</td>
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<td>Peace and Conflict Studies</td>
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<td>Refugee Reception Office</td>
<td>RRO</td>
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<td>Republic of South Africa</td>
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<td>Scalabrini Centre of Cape Town</td>
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<td>South African Human Rights Commission</td>
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  Fel! Bokmärket är inte definierat.
I see queues. Lines and lines of people. Lines beginning inside and ending outside. It is almost impossible to get in, so I stay outside. Yesterday there were fewer people. Maybe it is just because they are all jammed in the entrance, and there are not fewer people today. I regret not bringing my notebook and I scribble on the inside of my hand. I think there is around 50 people here. I realise that everyone has numbers on their hands today, yesterday it was only a few. It is tiny round stickers in neon colours with handwritten numbers on them. I do not understand why they would need to queue when they have numbers. They different colours probably have a purpose. I see a group besides the line without numbers. They do not look different from the rest; they are all in semi-worn clothes, all males, and probably all in their twenties or thirties. Some of them sit on steps in front of the clinic, others stand. They form an oval circle, and they do not appear to be concerned with getting in line. I position myself on a sunny spot on the step close to them. One of the younger men looks at me and says, ‘Oh, you are foreigner too?’

At present, United Nations High Commissioner for Refugees (UNHCR) estimates that there are more than 65.6 million forcibly displaced people in the world (UNHCR, 2017). While much attention has been given to migration patterns in Europe and the global North, it is in fact so that more than 84% of the world’s displaced people live and reside in the global South. South Africa, a country that categorises as a middle-income country, has a population of 56.52 million people, and is a prosperous developing country, is often referred to as one of the more stable and developed states on the continent. This makes it a desirable destination for refugees and asylum seekers fleeing war and conflict, as well as economic migrants travelling south in pursuit of better life opportunities. Between January and December 2015, Department of Home Affairs (DHA), which manages asylum application in the country, registered 62,159 asylum applications (Department of Home Affairs, 08 March 2016). Scalabrini Centre of Cape Town (Scalabrini) wrote in their Annual Report 2016-2017, that the DHA ‘turned down 81% of the refugee applications compared with the international average of 21%. In 2014 and first half of 2015, more than 150,000 people from 24 countries applied for asylum in South Africa’. Though the exact number of the refugee population is unknown, the South African Human Rights Commission (SAHRC) stated that South Africa hosts 91,043 asylum seekers and 218,299 refugees in 2017, emphasising that migration to the country is continuing (21 June 2017).

Known to host a large amount foreign nationals within its’ border, the mere presences of foreign nationals, however, does not guarantee inclusion and integration into societal structures, local conflict management mechanisms, or community development initiatives (Chiumia and Meny-Gibert, 10 August 2016). So, despite the transition to democracy in 1994 and the status as a well-functioning African country, conflict and violence in various means and forms are still present in contemporary South Africa, much of which relates to fear of foreigners and omnipresent feelings of xenophobia, the deep-rooted fear and dislike of foreigners by South African nationals (Nyamnjoh, 2014). Neither migration nor migration trends are the topic of this thesis. Still, it is important to understand that migration can contribute to development, if, of course, foreign nationals can effectively integrate so that they are able play an active role in society. While this argument is accepted by the South
African government as a means to reduce unemployment and corruption, and improve public service delivery to meet current demands, the actual realisation is not possible in a divided society with unsustainable financial structures and parallel development (National Planning Comission, February 2013).

Xenophobia has previously resulted in discriminatory outbursts and violence against foreign nationals. Foreign nationals - that is refugees, asylum seekers, and migrants – and xenophobia have become an increasingly area of interest in the context of South Africa, especially in the aftermath of the xenophobic violence in 2008 and 2015 (Chughtai and Haddad, 2015, Hickel, 2014, reporter, 21 February 2017, Sosibo, 24 April 2015, Tawengwa, 17 April 2015, Crush and Ramachandran, 2009, Du Plessis, 6 June 2015). The waves of xenophobia are expressions of how easily deep-rooted hostility can spiral into organised violence, and how violation of the rights and personal security of refugees and asylum seekers can amount to local and regional instability. Prejudices against foreigners are common in South Africa, and the foreigners are often believed to exhaust the labour market and public services. The image of foreigners as a threat to security, particularly with regards to black foreigners, varies along socioeconomic and different national and social groups – but discrimination and hostility can be found in various forms and levels ranging from organised violence in townships (informal or formal underdeveloped settlements located on the urban periphery, mainly inhabited by black peoples) to systematic discrimination in government institutions such as the DHA. These dynamics breed self-reinforcing criminalisation and scapegoating of foreign nationals while widespread xenophobic attitudes in South Africa permit the marginalisation of an already vulnerable group, allowing for arbitrary practices in government and the creation of formidable obstacles in accessing services, including health care (Crush, 2 June 2013, McMichael, 20 July 2012).

Aside from local hostility, the prevalence of xenophobic attitudes has, as mentioned, been linked to public institutions, including the DHA and the South African Police Service (SAPS) (Amnesty International, 24 February 2017, Dodson, 2010, Misago et al., UNHCR 2015, Musuva, 21 June 2015). Even though Crush and Tawodzera (2014) have documented xenophobia against foreign nationals in the health sector, little attention has been given to experience of xenophobia within this public institution, a space that is normally associated with equality, hospitality, aid, and humanitarian assistance. This topic area is increasingly interesting to examine given the recent national policy development in the country, namely the National Health Insurance Plan, introduced in 2011 by the Zuma administration. This policy was finalised and gazetted in 2017. By conducting a qualitative field study, this thesis will examine how the public health sector is experienced by refugees and asylum seekers and aims to contribute to the understanding of intergroup relations and conflicts between foreign nationals and nationals given that the continuous presence of foreigners in South Africa appear to spark local, regional, and national instability.
1.1 Statement of Purpose

The aim of this thesis is therefore to apply Esses et al.’s Instrumental Model of Group Competition from 2005 to analyse the relation between refugees and asylum seekers and South Africans in the health sector based, mainly, on the qualitative interview material gathered during fieldwork in Cape Town, South Africa during Spring 2017. In doing so, the thesis aims to contribute to an understanding of the on-going tensions between nationals and refugees and asylum seekers, which often appear to result in, or contribute to, marginalisation and violence as destabilising factors in society. The usage of the in-depth interview method is supplemented with secondary research methods (see more in Chapter 4), such as participant observation and informal meetings with relevant actors, which were conducted in attempt to create valid and reliable empirical material, subject to a theoretical analysis. Moreover, it is contended that the insight of refugees and asylum seekers are important to understand the relations and (violent) conflicts to complement the position of official management and national governance, if xenophobia is to be eliminated, especially considering the re-emergence of xenophobia in various degrees and forms in contemporary South Africa. In that sense, this study strives to provide an in-depth understanding intergroup relations and conflicts as experienced by refugees and asylum seekers in Cape Town and will, hopefully, provide empirical findings that can direct future research on xenophobia in South Africa.

1.2 Research Question

How is health access experienced by refugees and asylum seekers in Cape Town, South Africa, and how can the experiences shed light on intergroup relations between refugees and asylum seekers and nationals affiliated with the health sector?

1.3 Definitions

In this thesis, the term foreign nationals will be used broadly to include all foreign nationals residing in South Africa, including documented refugees, asylum seekers, and migrants (regular migrants) as well as undocumented people (irregular migrants). It thus applies to all non-South Africans currently living on South African territory.

The Refugees Act (No 130 of 1998) gives effect to relevant international legal instruments relating to refugees and governs all matters related to the reception and recognition of asylum seekers and refugees in South Africa as well as to provide for the rights and obligations which flow from such status. The term asylum seekers refer to the people who have applied for asylum or refugee status but have not received a decision on their application and are registered as asylum seekers by DHA. They are given temporary asylum seeker documentation, referred to as Section 22 permits, which grants these people have the right to study and work in South Africa and access services, including healthcare. These permits are valid from one to six months and the asylum seeker must renew the permit until they are recognised as a refugee or are found not in need of international protection. The
The term **refugees** refer to those who have been formally recognised by DHA as refugees and possess Formal Recognition of Refugee Status documentation, commonly referred to as a Section 24 permit, valid from two to four years. A refugee’s status may be reviewed to determine if it is safe for that individual to return to their country of origin. A refugee may also possess a Refugee Identity Book which provides the refugee with a 13-digit identification number like that of a South African citizen. Section 22 and 24 permits do not have this number and are issued on A4-sized pieces of. The term **undocumented** will in this thesis reference to foreign nationals who have entered the country without government approved authorisation.

The term **xenophobia** is understood as ‘the deep dislike of non-nationals by nationals of a receipt state’ as per the definition adopted by the SAHRC, coupled with the Oxford English Dictionary’s broader explanation, which reads that xenophobia is the ‘dislike of or prejudice against people from other countries’.

### 1.4 Link to PACS: Health and Peace: Past and Present

Health-sector initiatives are more frequently viewed as potential contributors to post-conflict peacebuilding. The policy and planning framework ‘Health as a Bridge to Peace’ supports health delivery in conflict and post-conflict settings and promote peacebuilding efforts. The framework builds on the idea that health, because of its universal recognition and fundamental value, can create a bridge to peace and generate solidarity among people across political, socioeconomic, and ethnic differences. According to Garber (2002), health orientated efforts under Health as a Bridge to Peace broadens the commitment ‘humanitarian ethos of health care’ in conflict and conflict-related arenas (p. 71-72). Thus, the approach commits to the idea that health both promotes peace and/or reduces conflict. As outlined above, it also positions armed conflict as a global public health issue through attention to sanitary, nutritious, medical and mental foci. Garber further argues that risk of malnutrition, poverty, and displacement are inherently linked to the rapid spread of disease (p. 72). Such efforts cut across peace-making, peacekeeping, and peacebuilding, and can in that sense act as unique medium. Health efforts become ‘constants’ in the war/conflict to peace transition amidst changes and transitions. In sum, health can function a ‘bridge for peace’ in two ways: where humanitarian relief is used as a response to direct violence during conflict or war, and where health system reconstructions can contribute to re-establishing the social contract and legitimacy of a government in post-conflict settings for peacebuilding or peace promoting purposes.

In the past few decades, there has been an increasing commitment to study the connectedness between peace and health. The idea of health in relation to conflict prevention and peacebuilding on an international level can be found in preamble of Constitution of the World Health Organisation (WHO): ‘The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and State’ (WHO, 1948, p. 1).
Health is accepted as playing an important role for peace promotion in violent conflict and war, and therefore often with a humanitarian aspect (WHO, 2015). Projects such as ‘Peace Through Health’ and ‘Health as a bridge to peace’, mentioned in the introduction (Chapter 1.1), demonstrate the importance of health in and after conflict as well as importance of role of medical practitioners as peace facilitators and monitors of new peace trends (WHO, 8-9 July 2002, pp. 3-6). More practically, health-related work and medical practitioners are thought to uphold humane and equal treatment for individuals, despite the divisions and conflicts created by violence and war (Arya and Santa Barbara, 2008, chapter 11, pp. 111-115). This emphasises the presence of health actors in humanitarian action.

It is also worth considering that health system and access are important factors when addressing security of individuals and livelihoods through emergency care, primary health, and disease prevention. Moreover, an effective health system can be said to embody to governments obligations to fulfil the needs of its people:

‘Healthcare systems are ultimately a reflection of the societies in which they develop – the fundamental changes in our healthcare system mirror the desire for change in our country’ (Dr. Anuschka Coovadia, 5 February 2016).

According to the WHO, the view of health must address more than the absence of disease, pain, and physical deficiencies. Health should rather be a condition of physical, physiological, and social well-being (Unknown, 2009, World Health Organization, 1948).

In same fashion, Nordstrom (1998) argues that healing the wounds of war are not limited to the physical but includes emotional and social well-being too. ‘Wounds of war’ are often associated with frontline realities which is highly influenced by militarisation, combat violence, and aggression. This is certainly relevant to consider in relation those fighting at the frontline, or caught on the frontline of war. A ceasefire may instantly spare lives and create space for attention to injured soldiers and civilians, but what about mending relations? And what mechanisms are in place to transform a war or conflict settings? Might it be so, that war resolution and peace-making often tend correspond to norms of war? Perhaps this is a necessity to engage with conflicting parties amidst violence. By giving attention to mental and social-wellbeing, responsive efforts could also focus on including human capacity and relations between people, between groups, and people in relation to structures. Interestingly, these are also crucial factors in peacebuilding. If there is a society to return to, enduring a disease or injury can, practically, be paramount for (re-)entering society. However, it does not equip an individual emotionally to deal with society’s structures nor does it secure the ability to enter the labour market or manage livelihood. Consequently, there must be a shift from cultures and norms of war; settings that do not encompass personal and collective security, physical integrity, and political participation (Ruger, 2010). In South Africa, xenophobic violence is an obstacle to such realisation. While the ongoing xenophobic violence cannot be cate-
organised as war, conflicts between foreign nationals and lower-income black South Africans can firstly be categorised as intergroup conflict. Secondly, elements of intent and action in ‘dealing with the foreigner’ add to the horrors of direct, spatial violence, and differs from for example stabbings, which are common in South Africa. For example, lootings of foreigners’ spaza shops (referring to small-scale informal shops located in townships) and usage of necklacing (referring to the practice of lighting fire to gasoline covered tired) constitutes organised violence. Ending the actual violence is one thing, preventing it from reoccurring is another. What we might call ‘norms of protracted, intergroup conflict rooted in xenophobic violence’ must be eliminated and transformed into something that allows for, at least, non-violent co-existence. ‘Un-educating war education’ and ‘reintegrating back into a healthy lifestyle’ can in that sense be seen as a form of peacebuilding; processes that need to ensure that conflicts do not reoccur and that reconciliation addresses the roots of the problems (Nicolson, 3 February 2016, Nordstrom, 1998, p. 114).

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 1948).

The thought that health is not merely the absence of injury or disease, is similar to the idea that peace is not merely the absence of violence. Galtung (1991) states that health and peace both have normative approaches that depend on interdisciplinary cooperation and further that, ‘health is for a person, what inter-state/nation peace is for the world, and intra-state peace for society’ (p. 1). He, too, identifies the role of the professionals but further argues that peace scholars as well as medical practitioners are committed to harm prevention, human security, and general well-being (ibid, pp. 13-14, Galtung, 1996 pp. 16-17).

Peace requires opposing parties to do more than ending violence and harm of the other. For the peace to last, the processes must rely trust amongst the people and across social groups (Keefer and Knack 2000 in The Presidency, Inaugural Meeting 11 May 2010, p. 26). In other words, where one can find direct, structural, and cultural violence, health as per the WHO definition cannot exist. Violence, in all forms, can accordingly be viewed as a threat to health. In turn, ill-health, whether physical, psychological, or social, may cause violence; hence, peace cannot be achieved without a certain level of health. Besides the humanitarian and normative links between health and peace described above, it is worth repeating that access to health services mirrors the conditions of the society in which it is developed (Coovadia, 5 February 2016). In other words, it embodies policy, and effectively shows the extent to which it is inclusive.

1.4.1 SDG Goal 3: Health and Well-being

It is internationally recognised that many low- and middle-income countries struggle with access to health and health services, and oftentimes people in these settings are lacking access to safe, effective, and affordable care
and medicine, including vaccines. Sustainable Development Goal 3.8 states that achieving universal health coverage is important to promote health and well-being, endorsing equal access to health. In an article, Ataguba et al. (1 September 2014) state that remains of apartheid can be linked to social, economic, and health imbalances in South Africa. They note also that despite transition to democracy in 1994, the human development index has declined significantly, especially because of the high HIV prevalence, another issue addressed in the SDGs (SDG 3.3). The system is thus thought to be vital for the health of the entire population and the increase of health equality. Currently, only about 16% are covered by the insurance schemes of South Africa (Lamble, 28 July 2017). The rest are dependent on public health services, which stands in stark contrast to the services and means of the private sector. The two-tier system is thus an example of treatment and access segregation on the basis of socioeconomic lines (Republic of South Africa, Thursday 10 December 2015, chapter 1) and is exemplified by a situation where:

‘(..) Much of the public health care infrastructure is run down and dysfunctional as a result of underfunding, mismanagement, and neglect’ (Mayosi and Benatar 2014).

Accepting the health of refugee and asylum seekers as a precondition for meaningful contribution to peacebuilding in face of xenophobia, will, in best case, contribute to the realisation of SDG 3, and thus assure health and well-being for everyone.

1.5 Notes on Existing Literature

Placing this piece in the larger body of literature within PACS is difficult because the content of thesis finds itself in the intersection of health as a holistic concept and intergroup relations and conflict as part of the study of obstacles in achievement of or possibilities for peace itself. Therefore, it is impossible to construct a conventional literature review because the existing material covers only one or two of the three intersecting topic areas. The introduction has shown that xenophobia in South Africa is linked to intergroup conflict between foreign nationals and nationals and further established this as a means to direct violence and instability. The previous section accounted for the normative link between peace and health as well as health and peace in the humanitarian contexts, pointing to the health’s potential contribution to peace. This idea can also be traced in literature on health and conflict in fragile states and health’s role in state-building (see for example MacQueen and Santa-Barbara, 2000, Philips and Derderian, 2015, Rushton, 2005, Schmidt et al., Tsai, Zwi et al., 2006). However, South Africa as post-conflict country does not resemble either of these contexts, suggesting firstly, the gap in literature on health and conflict in fragile states and health’s role in state-building and secondly, the importance of service delivery for peace in states that are not war-torn and/or without a functioning government. Finally, the literature on xenophobia in South Africa tells us very little about how, where, and when, and why intergroup relations escalate from non-violent to xenophobic. This thesis therefore adds to this understanding by trying to depict and describe intergroup relation in the health sector to see what possible peacebuilding initiatives should be attentive to.
Informal meeting with a township clinic foreign doctor, April 10th, 2017:

He explains that the facility’s resource shortage is very problematic. He points out some things, I have heard before, ‘there aren’t enough of us to care for all of them’, and ‘when we are enough, there is not enough equipment, such as blood, for example, let alone proper equipment’. It is a logistical thing as well, he states – they simply do not have the physical room for all the patients on a busy shift. Despite these very severe difficulties, ‘they manage’, he says. He is clearly proud of the care and assistance that he provides. He is educated and trained in Europe, and he is used to working in completely different environments, ‘but here, here, I have a sense of purpose – I am actually doing a difference!’. I ask him if he can identify the biggest problem and his answer was:

’Sof many people will walk into the clinic days, weeks, months, years after a disease or an injury has occurred. And you know why? Of course, there is the element of education, some of them do not even know when to go to see a doctor and when to go to the hospital, and they aren’t able to verbalise their symptoms or pains. The others, and this is the worst, they simply cannot come here because they do not have money for transport. And so, simple conditions and scratches become protracted illnesses and severe infections’.

2.1 The South African Context

As briefly mentioned in the Introduction in Chapter 1, The presence of foreign nationals (refugees, asylum seekers, and migrants) in South Africa can be said to have created new forms of social division. Tensions in the informal settlements mostly occur between people who share a common socioeconomic positions but do not share the same access to services in South Africa (Dodson, 2000, p. 141). In informal settlements, South African nationals live alongside foreign nationals, all belonging to the lower class (poor) and/or informal economy (not necessarily poor) (Crush, 2008, Dodson, 2010). The social effects of structural invisibility and social exclusion disproportionately affect the communities. Perceived differences between people based on nationality and documented status contribute to intergroup tensions, seen in its most extreme form during the xenophobic attacks in 2008, 2010, and 2015 (Patel, 28 May 2013). Reasons for migration to South Africa are multiple. Movement can have cultural, economic, political, and social, as well as concerning safety and asylum motives. It is a phenomenon that has different push and pull factors for each moving individual (Lee, 1966). Additionally, there is also significant numbers of internal migration throughout the country because it is been shown that the are (Chiumia and Meny-Gibert, 10 August 2016). This is worth mentioning because it has been found that it is areas where new internal migrants mix with foreign nationals that are prone to xenophobic violence (Misago, 2011).

2.1.1 Legal Framework

Under the 1951 Refugee Convention, refugees and asylum seekers are entitled to adequate, accessible, timely, and efficient health. This is, according to South African Human Rights Commission (21 June 2017), ‘echoed’ in the Universal Declaration of Human Rights (UDHR) from 1948, health is recognised as a human right; Article 25 and states, ‘the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services’. The responsibility to
ensure the right to health is enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR) in Article 12. South Africa has ratified this agreement and thereby commits to health as a human right. In 1996, the country became party to the African Charter and under Article 16 the state must take necessary measures to protect the health their people and to ensure that they get medical attention when needed. Read together with the Constitution,

In the Chapter 2 of the Constitution of South Africa, the Bill of Rights Section 27(1) outlines that everyone has the right to healthcare access, including reproductive services and emergency care treatment (The Parliament of South Africa, 1996). Under the National Health Act No. 61 of 2003, all persons, including pregnant and breast-feeding women and children under the age of six, have the right to state funded primary healthcare. Similarly, refugees and children of refugees are secured basic health rights under the Refugee Act No. 130 of 1998. Moreover Section 27(b) specifically states the entitlement to enjoyment of full legal protection, including the rights in Chapter 2 of the Constitution, and section 27(g) provides for the entitlement of basic health services as South African nationals. In practice, policy on determination of fees for patients states that non-citizens should pay full fees (excluding permanent residents, non-South Africans with temporary residence or work permits, and people from the South African Development Community that enter the country unlawfully).

This outlines refugees’ and asylum seekers’ equal claim to public health services and provision of free basic healthcare. The phrasing used in the Constitution underlines the legal duty of South Africa to respect, protect, promote, and fulfil people’s rights, and further explicitly states that social security should be provided to those who are unable to support themselves. In the right to human dignity, equality, and freedom, health is accepted in its broader definition. In that sense, health is associated with water, food, and social security, and it further emphasises that things such as food, and adequate housing are important for health. Equal access and health as a human right is central to promote (free) healthcare in the country, and can be found in South African Freedom Charter which was adopted by the African National Congress (also known as ANC, which was and is the governing political party in South Africa) in 1955.

One of the most recent attempts to defuse inequality in the South African health sector is the National Health Insurance Plan, introduced in 2011 by the Zuma administration. The National Health Insurance White Paper was released on Thursday, 11 December 2015. A White Paper is a government document which sets out the government’s position and proposals out on an issue. The aim of the NHI is to integrate affordable and equal treatment to all South Africans citizens and can be viewed the most progressive healthcare system to date. It may very well be that the NHI policy can and will generate positive change and increase equality - however, the implications for asylum seekers and refugees may foster further exclusion (as the extension of healthcare for refugees is not specified and the rights of asylum seekers are reduced). It appears that there is gap between legislation and actual health access. The relation between policy, in the form of the NHI, and actual access to
health in South Africa becomes increasingly important for refugees and asylum seekers and citizens alike, because their livelihoods are affected. The consequences go beyond the conventional understanding of health, i.e. to get well from illness. Xenophobia can be motivated by economic, cultural, and political factors, and the above implies that a significant element of the discrimination against foreigners from other African countries relates to health (Chughtai and Haddad, 2015, Crush and Tawodzera, 2014, Siegfried, 31 October 2014, Sosibo, 24 April 2015).

As mentioned, past and present xenophobic attacks on refugees and asylum seekers show that poor and underprivileged South Africans are implicated violence again foreign ers. At the ground level, attacks and hostility are often legitimised by narratives that centres on relative poverty, competition for resources and the idea that the foreigner steals ‘what belongs to South African citizens’ (Unknown reporter, 27 February 2017, Unknown reporter, 7 June 2013, Unknown reporter, 24 February 2017, GroundUp, 30 June 2016). Therefore, refugees and asylum seekers rightfully fear for their livelihoods and personal security, which also restrict their ability acquire and claim basic needs (Odhiambo, 20 December 2011, Odhi ambo, 18 March 2012). Another point should be mentioned besides the apparent hostility towards foreigners and the perceived impact on society. Namely, that this type of organised violence also appears to be an expression of how some social groups resort to ‘protect themselves from criminals’ (Hayem, 2013, Unknown reporter, 24 February 2017).

2.1.2 Emerging Complexities

The previous sections have showed that foreign nationals are at high risk of violent abuse and xenophobia. Alongside the structural challenges regarding documentation and discriminatory treatment, it is also difficult for them to enter the formal economy. While it is difficult to determine the origin of hostility, it is worth mentioning that xenophobia in South Africa is found in multiple levels of society, and the health sector is not an exception (Human Rights Watch, December 7, 2009b, Human Rights Watch, December 7, 2009a). Even prominent and powerful public person, such as former President Mbeki, reigning Kind of the Zulu Goodwill Zwelithini, and President Zuma, explicitly employ hate speech and hateful language, disclosing clear traces of propaganda in the political discourse (Du Plessis, 6 June 2015, Essa, 23 Jan 2015, Evans, 21 May 2008, Mutasa, 28 May 2013, Staff Reporter, 3 July 2008). The contempt for these people are deeply rooted in parts of society in form of cultural violence, where they are accused of ‘stealing women from local men’ and ‘exhausting resources and public services’, which should be reserved for South Africans (Dodson, 2000, p. 141, Dodson and Crush, 2004, Mayer et al, 2011, p. 9 cited in The Presidency, Inaugural Meeting 11 May 2010, p. 9). The competition for basic services and resources is further sustained by the mass unemployment rate, a factor that without a doubt contributes to the repulsive discourse on foreign nationals in the country.

Further, a complicating factor worth stressing is the lack of trust in President Zuma, the government, and public institutions coupled with the general perception that corruption is increasing (Newham, 17 Janarury 2014). Such
tendencies fuels competition for basic needs, jobs, and services, and may trigger both inter- and intra-group violence. Finally, it amplifies the need for equal treatment and access for foreign nationals in significantly reducing intergroup violence and ensuring that conflict does not (re-)emerge.

The poor livelihood conditions of foreign nationals increase their vulnerability in their communities as well as the public systems. It also highlights a problem that is threefold: on micro-level, foreign nationals experience xenophobia from South Africans, who perceive them ‘as stealing their resources’, which consequently creates violent and non-violent intergroup conflict. It accents the dangerous everyday life of refugees and asylum seekers, and their obstacles in establishing relations with South African nationals. On an institutional level, the same people experience access denial and discriminatory treatment in the health system, and the governments fails to provide this group of people with adequate health care as per their entitlements (which is also a severe infringement on human dignity), and finally this structural obstacle becomes direct too, as refugees and asylum seekers cannot rely the protection needed to secure their person and livelihoods from direct, structural, and cultural violence.

It has been established that xenophobic attitudes and attacks are widespread in South Africa. Triggers of violence are multiple and include inadequate service delivery and competition for resources. Hostile attitudes have been proved to be innately connected to health, and socioeconomic competition for scarce resources, and finally, the link to refugees and asylum seekers is not just about the rights and legal entitlements but also about safety of those who live and work in South Africa.
3.1 Instrumental Model of Group Competition (IMGC)

Realistic Group Conflict Theory can be used to explain prejudice and hostility between different groups. The theory centres on how perceived differences, conflicting goals, as well as competition between groups for limited resources generate intergroup conflict by attributing attention to situational factors rather than focusing on the individual’s internalisation of group difference in terms of identification. When necessary or desired resource are viewed as limited it will result in intergroup conflict, whether the limitation is perceived or realistic (Campbell 1965, pp. 289-292).

Based primarily on this theory, Esses et al. developed the Instrumental Model of Group Competition (IMGC) which was reprinted in the textbook ‘Social Psychology of Prejudice: Historical and Contemporary Issues’ written by Crandall and Schaller in 2005. The model was developed in order to combine the idea of the perceptions of resource availability and presence of a potential outgroup competitive will result in the perception of intergroup competition (pp. 98-99). In attempt to secure resources, the in-group will employ several strategies to reduce or eliminate the competitor(s), likely to result in intergroup (violent) conflict (ibid.).

3.1.1 Resource Stress

The authors use the term ‘resource stress’ to describe emerging perceptions that resource access in society is reserved for another group. Firstly, such resources can both be concrete, as for example health service delivery, or abstract, as for example power or status. The theory consequently takes the perception of competition for scarce resources, concrete or abstract, as a precondition for hostility and xenophobia. When one group perceived the other group as a beneficiary of the resources, the group will thus perceive themselves as deprived from the resources they are entitled to. Secondly, in the case where the one or more resources in society are unequally distributed in society, there is a likelihood of underprivileged groups developing the perception that resources are not available to them due to resource scarcity. Privileged groups, in turn, will assert that there is a risk of losing resources available to them in case power dynamics change. The main point is that all groups will have the perception that there are not enough resources to accommodate everyone. Thirdly, the desire to attain scarce resources will generate an increased value of those resource because of their scarcity, and subsequently, prompt individuals within groups to commit to a hierarchal society structure, wherein some are entitled to specific resources as opposed to others (Esses et al. in Crandall et al., 2005, p. 101).

3.1.2 Potentially Competitive Outgroup

The next strategy in the IMGP is the presence of what Esses et al. calls a potentially competitive outgroup. This group, or these groups, will be perceived as the competitors, rather than other groups in society. It is thus emphasised that the outgroup is not only distinct from the in-group but also from other groups in society. Outgroups
whose distinctiveness is in great contrast to one’s own group are likely to constitute the potential competitive outgroups and can include different types of factors, such as population size, appearance, and/or behaviour. What is interesting is that the such groups often possess similarities to the in-group as well. This is the authors explanation as to why in-group and potential competitive outgroup are competing for the same resource(s) (Esses et al. in Crandall et al., 2005, pp. 100-101). IMGC contends, however, that the degree to which the groups are similar or different, determines whether and to what extent an outgroup is perceived as a potential competitor. For example, in dimensions where specific quality is needed to obtain resources, the outgroups that are like the in-group are assumed to constitute the competitor. These dimensions include the ability to obtain a resource, for example skills or income, or geographic location. In other dimensions, factors such as ethnicity and national origin may be relevant, and thus, in such cases, it is more likely that the outgroups that are different from the in-group are considered the competition. Finally, outgroups that have an advantage in obtainment of resources and are ready to protect their access to resources also constitute a potential competitive outgroup because they have a better chance or ability to obtain and use resources (ibid., p. 101).

3.1.3 IMGC: The Perceived Group Competition

The IMGC differs from the realistic group conflict theory in that it focuses on both resource stress taken together with the presence of a potentially competitive outgroup will result in the perception of group competition. In that sense, the model can be seen as an expansion of realistic group conflict theory because it focuses on the internalisation and outcomes of resource scarcity and intergroup dynamics. The internalisation of resource stress will create the perception that whatever the outgroup(s) get(s), the in-group will not get. Or, where the outgroup gains, it will become more difficult for the in-group to attain desired or necessary resources. Such dynamics will further create anxieties and fears even if the resource stress and/or the potentially competitive outgroup is not realistic.

3.1.4 Three Strategies in IMGC

To identify and reflect upon different aspects of hostility between groups, IMGC proposes that there are three strategies that one group, the in-group, might attempt to reduce the competition of another group, the outgroup.

The first strategy posits that the reduction of competition of the other groups is likely to generate negative attitudes towards the outgroup, including the negative ascriptions of the outgroup’s members in attempt to delegitimise the worth of the outgroup competition. In doing so, the in-group will reduce its’ resource stress and may at the same time be successful in an actual reduction of competition. The authors note that in, ‘attempts to decrease the competitiveness of the other group may also entail overt discriminatory behaviour toward group members, as well as opposition to social programs that may help to increase the competitiveness of the other group’ (Esses et al. in Crandall et al., 2005, pp. 101-102).
The second strategy addresses the aspect that one group will seek to amplify real or perceived competitiveness of one’s own group. This is often expressed through in statements and actions to increase power, status, and wealth of in-group, so as to convince others, within the in-group as well as other groups, of the in-groups claim to resources. This is likely to yield social policies and practices that benefit the in-group specifically (Esses et al. in Crandall et al., 2005, p. 102).

The third strategy focuses on the avoidance of the outgroup(s) by means of creating an increased distance in space, time, or relationship. The authors give the example of how groups may restrict territorial access to reduce competition for resources (ibid.).

The abovementioned strategies will be applied to the empirical material generated and gathered in Cape Town in 2017 in attempt to understand how experience of health access and the South African health system by refugees and asylum seekers affect intergroup relations that have historically been susceptible to hostile attitudes and, in some cases, resulted in xenophobic violence against foreign nationals.
- CHAPTER FOUR: METHODS AND METHODOLOGY -

When I left South Africa in June 2016, I watched Table Mountain. It almost felt as if a dear friend said, ‘I am certain that we will meet again’.

The creation of this thesis has its roots in my six months stay in Cape Town, South Africa. I conducted an internship at Scalabrini Centre of Cape Town during my elective semester. Afterwards I was lucky to travel the Rainbow Nation. Since I left my position as an Employment Access Intern, I was certain that I wanted to write about peacebuilding in South Africa. Doing so turned out to be a long journey of personal reflection and academic pondering: I needed to development of an approach that would echo the landscape.

4.1 Ethnographic Research in PACS

The main empirical material was gathered during fieldwork in Cape Town in South Africa and therefore the findings of this thesis are largely dependent on the interviews and participant observation. Ethnographic field studies, that originally comes from anthropology, falls under qualitative research and is often used to study foreign cultures over long periods of time (Creswell, 2007, p. 69). The ethnographic approach also makes sense to adopt when the study is to look at specific social or culture-sharing group to understand more about a specific problem; in this case health rights, status, and refugees’ and asylum seekers’ ability to access health rights, as significant for building peace in South Africa in face of xenophobic violence (Harris, 1968 cited in Creswell, 2007, p. 68). This fieldwork was limited to 10 weeks, which meant I had to make certain reservations. Still, this method, drawing heavily on one-on-one interviews, seemed appropriate because the ethnography is deeply rooted in qualitative and context-oriented approach, in which the refugees and asylum seekers are described and analysed in their own context. In this way, I can begin to understand and explain the common patterns of the group (Creswell, 2007, pp. 71-72, Creswell, 2013, p. 48). This research thus uncovers context specific insight through participant observation - ‘being there’ - alongside in-depth interviews that allows for a nuanced perspective on the topic of xenophobia (ibid, pp. 68-9). At the same time, the submersion into the field forces me to re-evaluate assumed stances by continuously revisiting the main theme, namely the connections between health and peace and foreign nationals (Creswell, 2013, pp. 184-187). In that sense, the fieldwork experience creates a space to examine what it means to be refugee or asylum seeker in post-apartheid South Africa (Moustakas, 1995 cited in Creswell, 2013, p. 185).

Millar (2014) commits to four pillars in his ethnographic approach to peace and conflict studies. In an experimental approach to peacebuilding through interaction with the locals, he aims to understand their expectations and experiences. The first pillar relates to the lived experience, with a focus on generating research on groups that are normally excluded from research (ibid, chapter 3). In my fieldwork, I have not included South Africans in my primary research method (semi-structured interviews), but instead made sure to familiarise myself with their position through secondary research methods, for example complete observations. This should, according to Millar, ensure that the voices of the minorities are incorporated and considered, benefitting the local communities as a collective entity.
The second pillar relates to ethnographic preparation in chapter 5, Millar argues that one must understand the context of the country that is studied. One of the benefits of returning do fieldwork in setting that I was familiar with from working as an intern at Scalabrini and travelling in South Africa afterwards. Throughout my travels in country, I also decided to read South African literature and read both contemporary and classic fiction and non-fiction. Moreover, I attempted to increase and sustain my regional knowledge on Southern Africa in by writing my final essays at Goldsmiths University (study abroad term, Autumn 2016, between internship and fieldwork) on related topics (essays available upon request).

The third pillar aims to create insights from a variety of backgrounds and stresses the importance of local engagement (ibid, chapter 5). I explored on-the-ground activities through informal meetings with a variety of local organisation, initiatives, and persons that work with health, refugees, and/ or peacebuilding in Cape Town. I also enrolled in a conversational Xhosa language class which taught me basic greetings and interactions with Xhosa-speaking people in their own language. Consequently, I could move easier in township settings even though I ‘stuck out’.

The fourth pillar is outlined in chapter 6 and presents self-reflexivity as essential for understanding other ways of living. In many ways, I believe that cultural humility is something that one can practice, and in that sense one can, over time, become aware of one’s privilege and power. I have shared what I think I brought into the relations I have built through and in the fieldwork in the ethics section below (see chapter 3.5) and I have shared reflections, reactions, and experiences throughout the thesis before every chapter. I hope that this approach has made the accounts and analyses as transparent and honest as possible.

4.2 Limitations

Firstly, it is important to mention here that the NHI was approved by Cabinet in this final stage on 30 June 2017. Incorporation of this document has not been possible given the fact that the fieldwork had ended when it was gazetted. Moreover, the fieldwork experience changed the initial aim, which was more focused on how policy manifests in society. The ethnographic field study allowed for this to change, and I accordingly found that the connection between legal and lived experience disparities was rather linked to intergroup relations and xenophobia more than initially expected. Considering this knowledge, perhaps a phenomenological study could have been chosen, if one wished to focus solely on the experience of this phenomenon. The findings of this research will therefore suggest peacebuilding needs in relation to xenophobia based on the material from the 10 weeks of research, which does not necessarily qualify as prolonged time in the field. However, I did revisit my notes, work, and diary from my internship at Scalabrini during my time in the field, allowing for thick, rich description (Creswell, 2013, p. 252). It is in this way specific to Cape Town area within this period, and on the other, highly influenced by my subjectivity. I also recognise that some nuances and distinctions might not have been possible.
for me to understand or for the participants to communicate, given the fact that English is not the primary language of either researcher or participant. I also pay attention to the fact that research opportunities were restricted by the many public holidays, which meant that I was unable to visit all the clients and hospitals and take on all the meetings I had planned to. Moreover, some of the places mentioned by the interview participants mentioned, simply were not safe for me to go to alone, despite having a car available. This is also why the participant observation and informal meetings are not part of the analysis but is rather used to contextualise the interview content.

4.3 Fieldwork methods: Interviews, Participant Observation, and Informal Meetings

4.3.1 Primary Research Method: Semi-structured Interview

The thesis has adopted a qualitative approach to understand the experience of health by refugees and asylum seekers by means of semi-structure interviews with open-ended questions as the main method conducting ethnographic fieldwork. This interview method is beneficial to get detailed information and to assess how individuals feel and understand an issue (Creswell, 2013, pp. 239-240). It permitted a level of flexibility to follow and trail information that emerged during the interviews, without drifting off topic, and it meant that interview participants could influence the direction of the interview. Ultimately, this allowed the accounts to stay closer to their experience and minimised the risk of asking leading questions.

Interview setting

The interview guide is available upon request. All participants were talked through the consent form just before the interview, and I was very careful in reading it with them to make sure they understood it before beginning the actual interview. I conducted ten interviews with refugees and asylum seekers from Advocacy and WP during my time in Cape Town. The duration of the interview varied but all of them were conducted at Scalabrini. The semi-structured interview conducted at Scalabrini, a place familiar to them, thus creating a space where the participants could share their insights in a secure environment. I made sure to conduct interviews behind closed doors in the hope that it could eliminate the feeling of ‘surveillance’ from staff or other clients. Before starting I asked them again whether they were aware of me recording them, and if they still felt safe being recorded.

Interview procedure

First, I explained to the participant that I was a student in Sweden and a former employee at Scalabrini, and that this material was to be used in my final assignment at university. Next, I asked the participants to tell me a story or something about themselves that they wished to share. Following that, I dived into the research topic by the participant for their definition of health. I, then, attempted to ask questions from the interview guide on health access, rights, and status which seemed relevant to the individual before me based on what they told me. Next, I asked about what peace was for them and how they experienced peace in their lives in South Africa. Finally, I asked if they wanted to share something else with me.
Interview overview

Ten interviews were conducted between 10th April 2017 and 3rd May 2017. Below details on each participant and interview are presented. To protect the participants all have been given nicknames:

<table>
<thead>
<tr>
<th>Date</th>
<th>Status</th>
<th>Participant</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: 10/04/2017</td>
<td>Asylum seeker</td>
<td>Emma, 28 years old from DRC*, arrived in 2010</td>
<td></td>
</tr>
<tr>
<td>2: 12/04/2017</td>
<td>Asylum seeker</td>
<td>Olivia, 29 years old, from Kenya, arrived in 2013</td>
<td></td>
</tr>
<tr>
<td>3: 13/04/2017</td>
<td>Asylum seeker</td>
<td>Anna, 43 years old, from DRC, arrived in 2008</td>
<td></td>
</tr>
<tr>
<td>4: 13/04/2017</td>
<td>Undocumented</td>
<td>Oliver, 46 years old, from Angola, arrived in 1993</td>
<td></td>
</tr>
<tr>
<td>5: 13/04/2017</td>
<td>Asylum seeker</td>
<td>Amina, 28 years old, from DRC, arrived in 2008</td>
<td></td>
</tr>
<tr>
<td>6: 18/04/2017</td>
<td>Refugee</td>
<td>Sophie, 37 years old, from DRC, arrived in 2002 or 2003</td>
<td></td>
</tr>
<tr>
<td>7: 19/04/2017</td>
<td>Refugee</td>
<td>Louis, 48 years old, from DRC, arrived in 2001</td>
<td></td>
</tr>
<tr>
<td>8: 20/04/2017</td>
<td>Asylum seeker</td>
<td>Noah, 37 years old, from Republic of Congo, arrived in 2011</td>
<td></td>
</tr>
<tr>
<td>9: 25/04/2017</td>
<td>Refugee</td>
<td>Lucas, 28 years old, from Somalia, arrived in 2007</td>
<td></td>
</tr>
<tr>
<td>10: 03/05/2017</td>
<td>Asylum seeker</td>
<td>Marc, 42 years old, from DRC, arrived in 2003</td>
<td></td>
</tr>
</tbody>
</table>

*DRC: Democratic Republic of Congo

4.3.2 Secondary Research Methods: Participant Observation and Informal Meetings

In the fieldwork, I decided to practice participant observation, meaning participating and immersing myself into the research field. I chose to do that to nuance and contextualise the interview material and to create a closer relation to the participants, the foreign nationals, and the conditions in their lives (Creswell, 2007, pp. 68-69). Participant observation as a term combines two contradictory words that represent a paradox. This paradox is a very fine way of expressing the strengths and weaknesses of the method itself (ibid, p. 72). On the one hand, the research is part of the participant’s setting through the involvement in their activities and the exploration of their environment. Assisting the WP with health-related workshops has allowed me to do just that. I was aware that this participation, did not make me an equal but rather it allowed for first-hand insights into everyday life in Cape Town as a ‘foreign national’. In contrast the observation is categorised as ‘seeing’ without participating. In that sense, the observations at WP’s health promotion projects were not complete observations because other participants, especially interview participants and/ or former clients, clearly thought that I was a Scalabrini staff member. Participant observation requires that one does both (Creswell, 2013, pp. 139-140). Therefore, I visited several health clinics and hospitals around Cape Town, as well as many of places mentioned by the interview participants. These included churches, markets, shops, and community areas. In attempt to make use of local knowledge relating to current peacebuilding and health initiatives without restricting myself to Scalabrini, I chose to conduct informal meetings with a variety of local organisation, initiatives, and persons that work with health, refugees, and/ or peace projects in Cape Town. All secondary material was documented by handwritten
field notes. Writing and documenting is not just about what is observed, given that all descriptions are based on one’s subjectivity and individual choice. I therefore paid attention to be accurate in my writing. I attempted to incorporate my own immediate reactions to events or to the observed setting to stimulate reflexivity and acceptance that the account will never become ‘the truth’. In conclusion, this approach provided a method to understand the foreign national’s life conditions through first-hand impressions, while at the same time providing the necessary tools to zoom-out and see the interview material at distance or from another perspective.

4.4 Interpretation of the Interview Material

The interpretation of the interview material was done manually. In doing so, I drew on ‘Tesch Eight Steps in the Coding Process’ (Creswell, 2013, pp. 247-249). Given amount and length of interviews, I adopted a simplification of the steps as described below. When I grouped emergent topics into categories inductively, I tried not to look for any specific answers. It was difficult trying to remain objective, when listening, replaying, and reading about the violence, trauma, and stress that some of the participants described.

1: I listened to recordings one by one and jotted down thoughts on the transcriptions.
2: I proceeded to read the transcriptions and notes. After each interview, I wrote down topics as they came to mind.
3: I collected the topics from all the interviews into one list (see topic list below).
4: I arranged similar topics into categories and named them. (see table of clusters below).
5: I re-visited the transcriptions and wrote the category names next to the appropriate segment of the texts.
6: I compiled the material accordingly and assessed each category by itself.

In that sense, the interpretation of the material founded in an emic approach, where the perspective of the subject is central. This will be contextualised by the secondary research material, and thus presents the etic account, in attempt to bring about the most authentic description of issue of xenophobic violence.

Topic List:
Women’s Health, Health Treatment, Health Access, Clinic/Hospital, Peace, Freedom, Safety, Religion, Job, Food, Education, Housing, Infrastructure, Legal Status, Authorities, Trauma, Stabbing, Us/Them, Xenophobia, Me/Others, Stress
### Table of clusters:

<table>
<thead>
<tr>
<th>HEALTH</th>
<th>PEACE</th>
<th>SOCIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Health</td>
<td>Peace</td>
<td>Job</td>
</tr>
<tr>
<td>Health Treatment</td>
<td>Freedom</td>
<td>Food</td>
</tr>
<tr>
<td>Health Access</td>
<td>Safety</td>
<td>Education</td>
</tr>
<tr>
<td>Clinic/Hospital</td>
<td>Religion</td>
<td>Housing</td>
</tr>
<tr>
<td>VIOLENCE</td>
<td>DOCUMENTATION</td>
<td>MOVEMENT</td>
</tr>
<tr>
<td>Trauma</td>
<td>Legal Status</td>
<td>Infrastructure</td>
</tr>
<tr>
<td>Stabbing</td>
<td>Authorities</td>
<td></td>
</tr>
<tr>
<td>Us/Them</td>
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<tr>
<td>Xenophobia</td>
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<tr>
<td>Me/Others</td>
<td></td>
<td></td>
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<tr>
<td>Stress</td>
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### 4.5 Validity and Reliability

Validity and reliability in qualitative research refers to accuracy of the findings and the ability to replicate the findings respectively (Gibbs, 2007 cited in Creswell, 2013, p. 251). With attention triangulation of findings of the interview material, I relied heavily on my secondary research methods because they allowed me to affirm or deny emerging themes, re-evaluate assumed connections, and put the findings into perspective (Creswell, 2013, p. 251). I also made sure to communicate with gatekeepers during and after the fieldwork period, in case I needed to clarify something or ask additional questions. Insofar as I could, I made myself available to the interview participants during my time in Cape Town, and I was lucky to talk to some of them several times, even though no follow-up was needed at that time. To foster validity and transparency, I made certain to communicate to the interview participants, my gatekeepers, and the staff of the Scalabrini Centre that the final thesis will be available for them to read. Note here, that I have not had the opportunity employ member checking (ibid). Earlier in this chapter (3.1), I made use of the four pillars used Millar’s (2014) ethnographic approach to peacebuilding in order to display my own bias by sharing considerations on my field experience and explaining my motivations for certain choices, for example with regard to my usage of field notes (Creswell, 2013, pp. 251-252). When presenting my research methods, I explained how the research was produced and under what conditions as well as explain what the material can say something about (chapter 3.3). In doing so, I have attempted to reflect upon my role as a researcher and explained some of the motivations for my choices throughout the research process. To work towards qualitative reliability, the interview guide will be available upon request. While it will be possible to for a researcher to ask a similar group the same questions and visit the same places I have been to, the nature of the ethnographic study and its methods means that a similar approach will, most likely, give a different insight.

### 4.6 Ethics

I familiarised myself with the ASA guidelines to assure that issues of confidentiality and representation of the research participants (ASA, Association of Social Anthropologists of the UK and the Commonwealth, 2011).
Accordingly, I have anonymised personal data of all informants (for example names and other revealing information), as I am aware of vulnerable positions of some participants, especially in terms of application status and that my participants would likely be traumatised or affected by war and/or refuge experiences. I was conscious that the work carried out at Scalabrini is dependent on the trust between the organisation and its clients and that my research should be in line with the organisation’s code of conduct. I informed participants that I wanted to use the findings of the research in my thesis and that they will be asked/informed in the case of future publication, or other use of their contributions. To secure the research participants, I created a consent form, which was approved by the gatekeepers at Scalabrini. A copy of this form is available upon request.

4.7 Methodology Considerations

This section aims to answer questions relating to ontological (the theory of reality) and epistemological stances (the theory of knowledge) in attempt to foster openness on biases and presumptions (Creswell, 2007, p. 17). It is not a secret that fields of health often adopt a positivist standpoint and quantitative methodologies (ibid, p. 20). When this thesis attempts to explore health as a significant for peace with a focus on a vulnerable and marginalised group, it makes several key assumptions, which connects it to transformative philosophical tradition (Creswell, 2013, p. 37-39). In emphasising the importance of the lived experience of refugees and asylum seekers in Cape Town as a marginalised and vulnerable group, the study has a focus on inequities based on ethnicity and nationality and socioeconomic class, which in turn has created asymmetric power relations, and it makes a link between political and social approaches to inequities. In that sense, I wish to research the local needs and examine the local perception in relation to policy as opposed assume the needs the people have (Milne, 2010, p. 75).

The qualitative inquiry values the insights offered from the social group in question, namely refugees and asylum seekers, as significant voices that are currently undervalued (ibid, pp. 23-4). Sustaining constructive development of peacebuilding should, in my view, benefit from contribution from refugees and asylum seekers. This means that the lived experience is what is keeping us from one verifiable reality. It creates a space for considering cultural and social factors of health of refugees and asylum seekers (Garro in Goodson and Vassar, 2011).

Anthropological methods involving close attention to the lived experience of participants offer an excellent way to engage with these experiences, as they are lived on the ground (Fassin, 2013). Engaging in everyday experiences allows one to see how relations amongst partakers are developed and how different attitudes towards the public emerge. Hence it becomes apparent how meanings are inscribed into the political and social contexts of refugees and asylum seekers. This perspective sanctions pieces to the puzzle that would otherwise stay unknown. This commitment, which can be said to be the core of participant observation, moves beyond that of theory and analysis and helps one to understand when and how discourses emerge (ibid, p. 622).
‘The public is ‘a social imaginary’ which ‘exists by the virtue of being addressed’
(Michael Mann cited 2002 in Fassin, 2013, p. 626).

Fassin (2013) contends that the conversation between the researcher and the researched ‘generates a circulation of knowledge, reflection, and action likely to contribute to a transformation of the way the world is represented and experienced’ (p. 628). At the same time, the researcher remains detached (though not unbiased) and embedded in a specific time and space. The researcher is then able to employ local narratives and multiple viewpoints (p. 628 and 642): ‘In the first case, it illuminates the unknown; in the second, it interrogates the obvious’.

Because reality is subjectively constructed and complex in nature, qualitative research as a path to knowledge is optimal when conducted in the relevant setting (Walliman, 2010, p. 128-130).

Finally, the findings of this thesis should not be viewed as the one truth or a final solution, but as a piece that has constructed knowledge on the topic by exploring local perceptions in Cape Town, specifically. Through this inquiry, it is possible to understand how intergroup relations links to intergroup conflict in the refugee and asylum seekers meeting with the health sector and its’ personnel.

‘I want to definitely relativize the impact of ethnography on political decision and social change. Yet, however modest, this contribution still matters’ (Fassin, 2013, p. 644).
5.1 Application of IMGC: Competition for Health Access and Service?

So far, this thesis has shown that the health conditions, including social well-being, for refugees and asylum seekers are negatively affected by insecurity and discrimination, and often relating to xenophobia, amidst already difficult livelihoods as foreign nationals in South Africa. Ten refugees and asylum seekers were interviewed during fieldwork conducted in Spring 2017. In this chapter, the general findings of how health access is experienced by refugees and asylum seekers in Cape Town, South Africa, and of how these experiences shed light on intergroup relations between refugees and asylum seekers and nationals in relation to the health sector. This is done through the application of IMGC to the empirical material will be split into three parts according to the three strategies outlined in the theoretical framework.

5.1.1 Strategy 1: De-legitimisation of the South African Others

The first strategy outlines that reduction of competition of the other group is likely to generate negative attitudes of the outgroup by the in-group and subsequently, negative ascription of the outgroup’s members in attempt to delegitimise the worth of the outgroup competition. In doing so, the in-group will reduce its’ resource stress and may at the same time be successful in an actual reduction of competition.’ (Crandall et al., 2005, pp. 101-102).

From the interviews, it became apparent that different degrees of negative attitudes towards the South African outgroup had emerged. While I believe that negative image of the South African other should be viewed as a spectrum, I think it is beneficial to separate the South African outgroup into two sub-groups because it was clear that the participants made a distinction between the South African health personnel and the South Africans outside the health sector, for example those from their own or neighbouring communities and/ or those South Africans who, like themselves, needed health services. Based on the participants’ experiences of the health sector and its’ personnel, two contrasting images emerged.

On the one hand, many described doctors and administrative staff as helpful and professional, even willing to provide services, and help in cases where people either did not have proper documentation, enough money, or showed up without an appointment. It seemed everyone knew (or perhaps rather: knew of) someone who had received assistance at a hospital ‘against all odds’. This perception was more nuanced than first anticipated, namely because access and treatment was, according to refugees and asylum seekers, present at the hospitals.

On the other hand, at the day clinics, township clinics seen as significantly worse than at the clinics in the centre, refugees and asylum were treated ‘like nobody’. Many expressed frustration and anger regarding the long lines and hours of waiting to be assisted. Based on my multiple observations at different day clinics around the city, it was obvious that waiting from 5am or 6am in morning to mid-day before getting assistance, was the reality
for many lower class and poor South Africans too. However, the refugees and asylum seekers generally believed that nationals did not face those same obstacles. Anna, 43 years old from DRC, noted that, the ‘sisis’ (meaning: sisters, term used for nurses) don’t care about us, they just say: “You fine! Nothing is wrong with you”. Sometimes the doctor doesn’t even see me or touch me’. While the refugees and asylum seekers generally agreed that the hospital was much better than the day clinics, and that the doctors at the day clinics much nicer than ‘the sisis’, several assumptions about the South African others surfaced too. These will be addressed under strategy 2.

The other group of South African others referred to the citizens, particularly the black South African, who was thought to have a significant role in the lack of safety in the country. Especially the participants from DRC highlighted how ‘foreigners fleeing from war would never be treated like that in my country’. Many appeared to be certain that it was only black South Africans, and not coloured, Indian, or white South Africans, who stab each other and other people. When I confronted the participants with horrible treatment of Rwandan people in DRC, they told me that those stories were not true. Marc, 42 years old from DRC, countered the image of the black South African as a stabber and someone who steals. He told me, ‘(..)it is because of the fathers, you know. They don’t have any work, so they drink instead. And then children have no father to educate them about respect’. This statement follows the research publish on the absent fathers (see for example: Gabarino, 1999). When I asked why this behaviour was prevalent among black South African, they initially answered that it is because ‘they don’t like us’ or ‘they say it is not our country’.

This shows the perception of the South African other is deeply extremely complicated because refugees and asylum seekers draw on ‘how things are’ based on personal experiences as well as experiences of someone they know or have heard of. It was therefore increasingly difficult separate prejudice and assumptions about ‘how things are’ from the specific experience of each participant. At the same time, the divisions between us and them was apparent in the movement between areas, separating (township) day clinics from big hospitals. The further divide between different medical staff and ‘normal’ South Africans emphasised that the image of the South African other as exclusionary of foreigners and marked by hostile attitudes, whereas the hostility from black South Africans in the township and communities included violence against foreigners.

Finally, what is important to note, is that these findings also suggest that the hardships of being unemployment, being black, and living in lower income areas, where direct violence, as a part of everyday life, apply to all regardless of one’s nationality.

5.1.2 Strategy 2: Legitimisation of Foreign Nationals as One In-group

The second strategy addresses the aspect that one group will seek to amplify real or perceived competitiveness of one’s own group. This is often expressed through in statements and actions to increase power, status, and
wealth of in-group, so as to convince others, within the in-group as well as other groups, of the in-groups claim to resources (Crandall et al., 2005, p. 102).

First, the South African personnel at the day clinics, often, weren’t willing to help. Amina, 28 years old from DRC expressed it like this, ‘(...)they just give us panado and send us home again. We, the foreigners, keep being sick and we keep being sick’. This picture shows very well, how many perceived the health assistance as favourable of South Africans and how the lack of assistance to foreigners is linked to their documentation. Speaking about the day clinics, some argued that ‘it is a problem, if you don’t have a paper’, while others told me ‘that it does matter if you have a paper, if it is not a South African paper’.

Second, it was apparent that the refugees and asylum seekers saw the health care, alongside other government services, in South Africa as superior to that of their home countries. Many told me stories of how friends and family members died ‘back home’ because they could not afford health care. Sophie, 37 years old from DRC, said, ‘we all just watch them die in front of the hospitals’. What emerged alongside these accounts, was the perception that (black) South Africans do not appreciate what they have. Lucas, 28 years old from Somalia, put it like this, ‘we, the Somali people, we work differently. All the time, we work. Maybe it makes us too closed (as a group) but when we work, we work hard’. Others were quicker to take a more hostile position, pointing fingers at the black South Africa, very certain that ‘they are just on their phones, talk on the phones, when they are supposed to work’.

Such accounts of the refugees and asylum seekers showed that the experiences of inclusion and integration into the South African community transferred accepted social norms and ‘proper’ customs from the respective countries of origin to the collective behaviour of the foreign nationals in South Africa as one group. While the above quote also indicate that the refugees and asylum seekers distinguish themselves according to nationality and ethnicity, the findings also suggest that there was a strong sense of collectivity, formed by a solidarity between refugees and asylum seekers when though the participants came to South Africa from different places. Even though the interviews touch upon different aspects of health, that is health in the broad interpretation as per the WHO definition, the usage of words such as ‘us’ and ‘them’ and ‘we’ and ‘they’ occurred with reference to both nationality and foreign nationality. This finding is important because it positions ‘South Africans’ and ‘the South African system’ as the outgroup. ‘The outgroup’ was characterised as unsympathetic and hostile ‘other’ that did not adequately understand the dire situation of the foreign nationals, perceived as rooted in blindness to realise that positive contribution that foreign nationals could make in the South African society. Many of those interviewed touched upon how South Africans wrongly assumed foreign nationals have the desire exhaust scarce resources. Other participants reasoned that this behaviour would not occur if ‘they’ (the South Africans) had a moral compass like that of the in-group, the foreign nationals. Here we find an overlap with the findings in strategy 1. In that sense, the foreign nationals perceived themselves as marginalised by them system and the
South African people as well as denied the ability to enter into society through health service on equal terms with the South Africans despite their right to health as outlined in Chapter 2.

For the refugees and asylum seekers, these conditions manifested in violent and hostile attitudes of the South Africans towards them, emphasising that the outgroup had no legitimate reason to ‘stab’ and ‘steal’ from foreigners; ‘They’, the South Africans, would, according to the participants, target foreigners when they prospered monetarily from informal and formal jobs, hence ‘making it’ when and where the South Africans did not manage to. At the same time, when in need of public services, including healthcare, the participants deemed the system as ‘better than back home’ but regarded their treatment as worse than that of nationals. Here it is important to remember the above. Namely, that the treatment and assistance in the health sector still varied, depending on the which ‘South African other’ they encountered and where.

As well shall see in the application of strategy 3, the negative ascriptions to the South African other (strategy 1) as well as the perspectives on the status of the South African other as enemy that employs illegitimate behaviour towards the in-group affect the conditions and behaviour of the refugees and asylum seekers.

5.1.3 Strategy 3: In-group Behaviour in Response to Perceived Competition

The third strategy focuses on the avoidance of the outgroup(s) by means of creating an increased distance in space, time, or relationship (Crandall et al., 2005, p. 102).

In the application of this strategy, it became clear that the in-group, too, was divided into subgroups. These, accordingly, shows that the avoidance of the outgroups has a variety of different factors to consider depending on individual in question.

The most apparent between the participants are there legal status, their nationality, and their gender. At the time of the interviews, six of the participants were asylum seekers, three were recognised refugees, and 1 was undocumented. It is important to note here was that the asylum seekers all would mention documentation as a factor for obstacles in accessing services and/ or as a factor for hostile relations with or violent behaviour from South Africans. These participants touched upon different aspects hereof. Firstly, which other research has documented as well including Scalabrini, the travel to RRO offices where the asylum seekers renew their permits (Jordaan, 3 June 2016, Landau et al., 2005, Scalabrini Centre of Cape Town, 2016-7, Siegfried, 31 October 2014). While the economic problems relating to this point was mentioned and is important, the psychological aspect was dominant as well. Some regarded the repeated travel as ‘tiring’ and ‘exhausting’, where other emphasised the stress relating to planning the travel and the fears relating to theft and personal security. Some of the participants with refugee status did mention problems relating to documentation, but only when speaking of friends or family and their past. What was interesting was that these participants, all expressed as wish to leave
South Africa because life ‘is too hard here’. Some of the refugees mentioned their wish to leave as well, however, they did not express the same exhaustion in relation to this aspect but described life as ‘difficult’, and seemed, to a point, to have expected the conditions of their lives in South Africa.

Next, the only two participants that did not mentioned a change in attitudes from before and after 2008 (see Chapter 2) was Olivia, 29 years old from Kenya and Emma, 28 years old from DRC, who arrived in 2013 and 2010 respectively. Noah, 37 years old from Congo did not refer to this shift as by personal experience but noted that others had said that ‘it was safer before’, even though I was unable to figure exactly what ‘before’ referred to. This suggests that refugees and asylum seekers, who were in the country at the time of the xenophobic attacks in 2008, all agree that it was easier for them prior to these events. Sophie, 37 years old from DRC, said, ‘I don’t know what changed but now they don’t want us here anymore. There is no place for us here. I just want to go, but I can’t.’

Another important factor that emerged was referred to by all the female participants. They talked about ‘pains down there’ (many pointed to their abdomen or vagina) or about extensive bleedings or abruption or significant changes in their menstrual cycles. There was no consistent behaviour attached to these ‘private problems’. However, they all said that they were reluctant to tell anyone about these problems and expressed great frustration in accessing health services to fix these problems because they believed it was embarrassing, either to tell their husbands or to talk to a stranger about it. None of the participants that had ended up accessing health services, either through public care nor Scalabrini’s SHAWCO pop-up clinics at the Scalabrini Centre, mentioned anything about sexual harassment, and it did not appear to be because they were hiding that from me. Rape and sexual assault was mentioned only in terms of something ‘other foreigners had experienced’ and only with references to township or housing areas.

What became apparent was that all the participants employed mechanisms that relates to what I will describe coping mechanisms of invisibility. Especially with regards to informal work, the participants said things like, ‘we just try to mind our own business’ or ‘we keep to ourselves, because it is safer’. The lack of inclusion and perception of the ‘South African other’ as dangerous can be understood as a driver to amplify informal and parallel society development by foreign nationals. In that sense, the marginalisation and exclusion seems to be reinforced by the refugees and asylum seekers own behavioural pattern because they perceive ‘staying to themselves’ is a safer option.

Those, who did not regard their health treatment and access as particularly problematic, still indicated that their care and/ or treatment did not match that of South Africans. When asking how they could know how the South Africans were treated, most referred to how the ‘sisis’ (nurses) at the clinics would ‘bump up’ South Africans on the waiting lists. The participants who mentioned this were unable to elaborate on this or share specific details. What was interesting in this regard, was the specific focus on the lack of dignified treatment – even in
cases where the meeting with the health sector could be described as ‘successful’. Many gave the impression that they would postpone ‘mission health clinic’ to avoid ‘having to deal with them (meaning: South Africans) not knowing what to expect’.

Finally, this shows a trend of behaviour coloured either by inactions or passiveness or actions that contributes to further exclusion of foreign nationals. As mentioned in chapter 4 on methods, it should be noted here that the reasoning and experience of the participants is not viewed as a sample of all refugees and asylum seekers. Rather, it is suggested the experiences and accounts to be an example of how intergroup relations between nationals and foreign nationals in Cape Town, South Africa are impact intergroup dynamics towards intergroup hostile attitudes and behaviour because internalised perceptions regarding resource scarcity (real or perceived) create competition between groups.

5.2 Emerging Themes: Integrating the Etic and Emic Perspectives

Two key themes have been identified based on the perceptions of the refugees and asylum seekers based on the findings from the three strategies. Each theme will be presented briefly before engaging in a discussion of the findings.

5.2.1 Theme 1: ‘Health Is... Not Stress!’

In the beginning of each interview, I attempted to figure out how health was understood and experienced by the refugees and asylum seekers. Just as the broad definition of health provided by WHO expresses different kinds of health, so did the participants. This spectrum of understandings will be presented in this section.

Food, a basic need without which we ultimately starve, was expected to be central to the refugees and asylum experience of health. Each person had specific way to stay healthy: exercising, reducing meat intake, avoid pap (also known as mielie/mieliepap, a specific form of maize porridge). I sensed a tone of disapproval towards black South African’s eating habits and food culture. One specific account stood out, Olivia, 29 years old from Kenya, reflected on the long-term effect of bad lifestyle choices:

‘Health-wise... I think in terms of food first. A lot of people don’t like to eat healthy, they don’t eat healthy. And they use, things, like drugs and everything, and it affects them. To me, that’s not healthy. Because sometimes they lack knowledge’.

She concludes by telling me that this knowledge should be passed on the people while they are young. So that it becomes normal, stressing that when something is ‘normal’ it is easier passed on to the next generation. One thing I realised during the writing of the analysis was that none of them talked about difficulties in buying or
financing food. This finding was surprising to me because I knew that some of the participants were unemployed (at the time) and many only had a very low income.

Lucas, 28 years old Somali man, first told me, that he did not know anything about health because he never had his health checked in South Africa. For the most part, I believe he was attempting to answer my question from a scientific standpoint. He proceeded to explain that he had been to the hospital with an injury in 2016. He got this injury when his spaza was looted. This expresses a view wherein internal and external health are separate and further, that ‘an injury’ is not necessarily understood as a threat to health.

When referring to knife stabbings, participants would move a fisted hand against their bodies, showing me the movement and pace of a knife stab. This movement left an imprint on me. I had quite the shock, when Anna, 42 years old from DRC, did this during her interview. In contrast to this relatively aggressive movement, the serenity of her following comment reminded me that direct violence is the next-door neighbour to most all the interview participants:

‘They stab people. They stab and they die’.

When the participants were describing the everyday violence in their lives, the actual violence appeared to represent threat to their social well-being as well as burdening their mental state. Their perceptions showed that the effects, caused by violence – and the perception of this violence being xenophobic in nature specifically, compromised their movement, effectively depriving them of autonomy in their everyday life.

When Amina, 28 years old from DRC, told me that she lives in an area with many coloured people, she said,

‘I don’t think coloured people have these problems. Only black. Because with coloured [people] are fine! We are safe. We are even safe if we stay with coloureds (..) Most foreigners I know, they are now staying in places like Gugulethu* and all these places where they get cheap accommodation, but they are not safe because there are black people on that side. So, they are killing them. Almost every day. They are not safe. Because they cannot afford to pay the rent [elsewhere]. That’s why they have to go and stay there’.

*Gugulethu (meaning ‘Our Pride’ in Xhosa) is a township, on the Cape Flats.

This sentiment highlights many foreign nationals’ views of black South Africans as being xenophobic and as the individuals who perpetuate xenophobic attitudes and violence. In a sense, it also highlights the highly-fractured nature of South African communities, where segregation, even in the post-apartheid dispensation, remains
a constant and visceral presence. It may also lead to foreign nationals choosing to not integrate into South African communities and choose association with their own community groups only, further hardening divides.

The most common topic in relation the definition of health and what stands in the way of realising that was stress. The participants did not only express frustration regarding their own situation but also on the stress of the people in their lives. I found that the mental pressure related to different issues: applying for jobs, securing housing, or education for their children, planning your day to make use or not make use of public transport to stay safe.

Taken together, the findings show that the experience of health by refugee and asylum seekers is connected to the missing ability to control or secure everyday life, placing importance on health as mental and social well-being before physical well-being. Marc, 42 years old from DRC, phrased it eloquently:

‘The first thing you need is to be free. If you are not happy, you can’t have [attain] health. You must be happy, you must be free’.

5.2.2 Theme 2: ‘Hospital v Clinic, Heaven v Hell’

Olivia explained that she went to one of large public hospitals in Cape Town, and continues:

‘This is what I have, a passport. I told him (a doctor), “this is what I have”. And he told me, “you know what, emh, here you must go to, through clinic, for them to write a letter”. But I explained to him, I bleed- I don't know, because even in clinic, they won't help, or aren’t able to help to me. Because this is a big hospital, I just need assistance. Then, you see, he asked me, “are you bleeding?” I said, I am bleeding. And then, I was, I don't know if it was, I was just lucky or what, and then there is- he just took me and took my papers and then there was another doctor, who said, “Why would you send people here? They didn't even book an appointment!” ’

First, a gynaecologist told the Olivia that there was nothing wrong with her, later she found that she needed medicine that she could not afford. It was unclear exactly who told her this, but in the end, a doctor at the hospital told her that they would help her out anyway. This account represents the dominating perception among the participants, namely that the hospitals can accommodate and treat people according to their needs. In a way, this is not surprising because many of these hospitals perform services on deferrals from the (smaller) healthcare clinics that has fewer capacity to treat more people.

Treatment at these day clinics is a different story, according the to the participants. The day clinics are known to be overrun, crowded, and understaffed. The participants agreed that it was frustrating to one, wait in line for
hours and two, possibly face problems relating to documentation. During one of many chats with Advocacy staff at Scalabrini, I found that it is common that the asylum process is protracted, resulting in asylum seekers having temporary documentation for many years. This is also visible in the interview overview in Chapter 4 on page 22. However, participants generally declared the South African health system far superior to that of their home countries, and the free health care is highly valued by the refugees and asylum seekers. One participant disagreed. Noah, 37 years old from DRC, told me that he did not believe that one could get proper treatment in public facilities because, as he phrased it, ‘nothing that is free, is good’.

Another thing became clear, namely that the clinic staff was perceived to overcharge those without permits based on their nationality. When I asked Emma (28 years from DRC) if she had experienced discrimination she said: ‘Yes, there is [discrimination] here, the xenophobia. If you don’t have the paper’. In South Africa, the primary health clinics are free, medical services at public hospital services, are not. Based on the findings, it is difficult to determine if this is known to them. Confusions about where to get what care, or talk to which person, seemed to stem mainly from language barriers. However, language becomes harsh in the dialogue between the staff and foreigner too, adding to the communication barriers, Sophie, 37 years old from DRC told me:

‘They are not friendly. They shout! They shout to you, they shout... The shouting is in English - it is not your language. First thing: you are scared’.

In quoting the above statement, compare Sophie’s experience with the following thick description from one of my clinic observations:

Complete Observation: Robbie Nurock Day Hospital, 89 Buitenkant Street, Cape Town, April 24th, 2017

The waiting room has a tense atmosphere. I am sitting next to the others on the brown benches. They remind me of the benches from the churches back home (in Denmark). Some talk, some do not. Others again save seats for friends. Most appear to have at least one partner in crime. I am here alone. I immediately think about a school cantina. The walls are covered with many random stats printed on A4 papers, information and campaign posters. It is messy and unorganised. Many of the things are torn or faded. On the wall opposite me in the top right corner, there are three framed portraits. I recognise two of them President Zuma and Health Minister Mbombo on the wall. On the one hand, the differences between people’s wealth is apparent. Among men with phones and headsets and women with purses and earrings, the homeless are easy to spot. And smell. Many appears to be carrying everything the own in bin bags. Their many layers of clothing seem too warm for the sunny Autumn day in Cape Town. On a regular basis, names will be called from the reception windows from around the corner in the entrance hall. People will shush each other when this happens: ‘Shhh! We cannot hear anything! Be quiet! Shhhhh!!’. The roll calls fuel a form of collective anxiety in the room. The noise pollution comes in waves, accompanied by hunks, wheel spins, and city sounds from the streets. It must be around 8 ‘Was
my name called? Did I lose my spot? I was here before him!’. It was suddenly clear to me that people in the waiting room viewed the possibility to secure a consultation as a lottery; maybe you’ll win, maybe you won’t.

I could not help but wonder if the refugee and asylum seeker from time to time would experience treatment as degrading, insufficient, or xenophobic due to general misconceptions. Most of the participants agreed that the doctor’s treatment was superior to the nurse (often referred to as ‘sisi’, meaning sister).

Now a reoccurring pattern emerged in the participant accounts on their encounters and interaction with the South African people. Refugees and asylum seekers do not feel that their presence in the country is wanted, and this social exclusion seem to fuel intergroup hostility. When I asked them to raise their options on this matter, it became clear that the hostility is a two-way street.

Anna recounted a visit the DHA office in Cape Town where she noticed the black South African employees outside, looking as if they were not working as hard as they should, in her view. She explained that she had not realised that they were, in fact, employees to begin with. She seemed irritated that they did not attempt to assist the many foreigners waiting there. When taking her fingerprint, they employee was texting on his phone. In the description of the officer, who told her ‘I don’t want to give you the paper, go back home’, she did a mocking imitation of his Xhosa clicks (interview 13th April 2017).

5.3 Discussion

The presence of refugee and asylum seekers in South Africa create intergroup violence based on nationality in the areas and townships where they live side by side with (black) South Africans. The presence of violence and the fear of risk of violence appear to fuel intergroup resentment. According to Dodson (2000), this can be explained by the fact that the two groups share same socioeconomic position but not same access to public services, resulting in increased competition for scarce resources. The lack of social well-being of the refugee became apparent in their frustrations attaining safety in their everyday life, and moreover positions them so that they are unable to improve their own situation and attain health, health access, and health rights.

At the same time, the dependency on documentation is increasingly difficult for refugees and asylum seekers to move around freely and access health. Restrictions imposed by the 2016 Refugees Amendment Bill complicates the asylum seekers right to employment, as an assessment is to determine whether the asylum seekers can sustain themselves for a period of four months. Only when unable to receive other assistance, for example by UNHCR, can the right to work be granted (Substitution of section 22 of Act 130 of 1998, as amended by section 15 of Act 33 of 2008). This situation is further complicated by the fact that asylum seekers must apply/renew permits at one of the few Refugee Reception Offices (RROs), and following that several trips back to the RRO of application are required throughout year for renewals; the struggle of obtaining and maintaining proper permits
becomes a problem in their job search and in keeping their jobs. This may lead to perilous employment situations, pushing people into informal labour. It is not uncommon to hire these people at lower wages and without benefits. Additionally, the travel is often dangerous and expensive, beyond the means of the asylum seeker. These conditions make it even more troubling that there is no procedure in place to handle rejected asylum applications, Talane (27 June 2014) explains that, 'This circumstance can lead to a number of potential risks, including corruption on the one hand and the abuse of state systems on the other. Mischievous officials may use the vulnerability of asylum seekers to solicit bribes in return for speedy service or irregular documentation'.

The division between refugees and asylum seekers and the South African people was apparent in the public health institutions too. With emphasis on unpredictable response and inadequate management by health staff and differentiated treatment, xenophobia is an obstacle to health care access by refugees and asylum seekers. However, perceived discrimination due to language barriers should be considered in this regard. Among others, Human Rights Watch (2009a and 2009b) have documented problems relating to health care access and service delivery in South Africa. These problems include discrimination, lack of awareness regarding the rights of refugees relating to access, language and communication barriers, problems with documentation, emergency care, fee payments, and inconsistent treatment. Crush and Tawodzera (2014) similarly found that nationality, language, appearance, and documentation are grounds for what they call 'medical xenophobia'. South Africa has seen structural violence in its health system before. During apartheid health care in was divided according to race, separating the white minority from the blacks and coloured, like townships and everything else in society, which restricted their movement of freedom. While current structures do not physically exclude refugees and migrants as such, it socially marginalises them.

Without dismissing the challenges that South African nationals have in accessing health services, it appears that nationals do not experience the same barriers in accessing health. The South African Department of Health (SADH) commits to recognise the right of refugee and asylum seeker to obtain healthcare, and the obstruction of the access to health of refugees and asylum seekers can therefore be problematised in relation to individual health and rights claim to the state as a service provider. Increasingly worrying is that the state’s international obligations to protect the right to life is compromised in relation to attacks on foreign nationals, without a proper response or commitment from the government to protect the lives of foreign nationals. Consequently, the refugee and asylum seeker persist to live in fear. It gives rise to questions of the accountability and legitimacy of the state, and it is an expression its inability and/or unwillingness to protect the refugees and asylum seekers within their borders.

The lack of state action to effectively implement both health rights, as found in international law and in domestic law, result in asylum seekers and refugees being unable to realise these rights. The participants even discussed active hostility on the part of the state in their attempts to access healthcare. Their inability to access healthcare, to attain 'health', therefore has great implications on everyday life, on the ability of foreign nationals to
contribute positively to the development of South Africa, and on the prospects for addressing the xenophobic violence and attitudes that are omnipresent in many aspects of life in South Africa.

Xenophobic violence shapes refugees’ and asylum seekers’ conditions and behaviour. Stemming from the act of violence itself, the direct violence, it positions the refugee and asylum seeker at greater risk of injury and premature mortality. Discrimination motivated by xenophobia are likely to generate reduced health because it imposes suspension of healthcare treatment, voluntarily or involuntarily. This process has escalating or de-escalating effect on the refugee and asylum seekers conditions and constitutes, what could be called, norms of protracted, intergroup conflict rooted in xenophobic violence. This structure, to which the legal practice is blind, further generates stress related to xenophobia and creates health needs, increasing likelihood of hostility between refugee and asylum seeker and the South Africans.
- CHAPTER SIX: CONCLUSIONS -

6.1 Conclusion: An Understanding of Intergroup Conflict in the Health Sector

How is health access experienced by refugees and asylum seekers in Cape Town, South Africa, and how can the experiences shed light on intergroup conflicts and relations in the health sector?

Revisiting xenophobia by means of an inquiry through health showed that the broad concept of health (health as state of complete physical, mental and social well-being) provides a way in which we can understand not only the individual and local tensions, while allowing for attention to the collective group dynamics.

Key themes showed that intergroup violence based on nationality is prevailing in the areas and townships where refugees and asylum seekers live side by side with (black) South Africans. The physical state of health encompasses threats or risk of threat to personal and security and safety primarily in the townships, and between black South Africans and foreign nationals. The presence of such violence and the fear of violence appear to fuel intergroup resentment and hostility between the groups. The lack of social well-being of the refugee became apparent in their frustrations in attaining safety in their everyday life. The ethnographic research highlighted that the perceptions of xenophobic treatment, especially in accessing healthcare, also fuel resentment and negative views on South African citizens on the part of foreign nationals. This is a highly problematic dynamic that engenders conditions for continual (and overt) conflict between these groups. It also results in the negative and circular trend where asylum seekers and refugees are unable to improve their own situation and attain health, health access, and health rights. Additionally, it found that a major obstacle to the realisation of health is connected to legal documentation as well as a lack of knowledge about the rights of foreign nationals in accessing healthcare with all parties – healthcare workers, the citizenry, and the foreign nationals themselves. Taken together, such strains should be seen as counterproductive to ending what I have called norms of protracted, intergroup conflict rooted in xenophobic violence. In this sense, the application of instrumental group conflict model indicates that refugees and asylum seekers need to be integrated and accepted in society to remain safe and attain basic livelihoods that can, in turn, benefit society and benefit the state.

Concluding, this thesis suggests that special attention should be brought to nurture the relation between refugees, asylum seekers, and South Africans. This requires that everyone’s rights are protected, and that livelihoods and physical security includes everyone who lives and works in the country, despite nationality and citizenship. The struggle to make this a reality constitutes an everyday life struggle for refugees and asylum seekers on the same level as many underprivileged black South Africans. Their obstacles and clashes with South Africans and the country’s public institutions can be said to generate a downward spiral of insecurity and multidimensional violence, subjecting them to structural and social exclusion, xenophobic violence, deprivation, and human rights abuse; an inquiry though the concept of health appears to show that such issues are significantly linked, and
thus also sustained, by a circle of hostility and mistrust between foreign nationals and South Africans, between an ‘us’ and a ‘them’.

6.2 Future Research: Intergroup Conflict in Cape Town, South Africa - What Now?

This thesis has shown that xenophobia is connected to and affected by encounters with the health sector and its personnel. While such perceptions are not ‘new’ in connecting hostile behaviour and violence between South Africans and foreign nationals, it has been shown that experiences centring on health can offer an insight to deepen the understanding of obstacles and hardships relating to xenophobia in the country, even though the extreme manifestations of violence against nationals, as seen during previous waves of xenophobic violence, seem to have lessened. This suggests that further insight into health of foreign nationals in other parts, especially other urban centres that host many foreign nationals, might be valuable to see whether the same trends can be found in other provinces and parts of the country.

Another aspect that has not been significantly covered in the existing body of literature on xenophobia in South Africa is one that this thesis has not expanded on either. Namely, the focus on the perpetrators of xenophobia. To that end, it might be interesting to apply IMGC to experiences and perceptions by South Africans. That perspective would allow for a richer perspective that could better illuminate the intergroup conflicts between South Africans and refugees and asylum seekers in the country. Finally, such empirical inquires could be undertaken with benefit be applied to other countries, wherein foreign nationals are documented to experience discrimination by nationals and might bring about results that could assist in explaining why xenophobia escalates more frequently to violent outbreaks in some contexts and countries as opposed to others.
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UNKNOWN REPORTER. 27 February 2017. Zimbabweans in SA say 'xenophobic attacks are political', engage ANC. *News24*.

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- OVERVIEW OF LEGAL DOCUMENTS -

In this thesis:
National Health Act No. 61 of 2003
Refugee Act No. 130 of 1998
International Covenant on Economic, Social and Cultural Rights (1966)
Uniform Patient Fee Schedule (2016)
Universal Declaration of Human Rights (1948)

Other legal instruments:
Convention on the Rights of the Child (1990)
Convention on the Elimination of All Forms of Racial Discrimination (1969)
Declaration Elimination of All Forms of Violence Against Women (2003)
International Covenant on Civil and Political Rights (1976)
United Nations Charter (1945)
WHO Constitution (1948)